PERSONAL INJURY CLAIMS • CLINICAL NEGLIGENCE CLAIMS
FREE MEDICAL AIDS & ADAPTATIONS ADVICE
Please ensure all correspondence is addressed to our Head Office
Client consulting rooms throughout England and Wales
Telephone calls all offices: 01482 345800
Registered Head Office:
Rapid Response Solicitors
Beverley Road, Hull HU6 7DQ
Fax: 01482 348924
Web: www.rapidsolicitors.co.uk
A Quality Assured ISO 9001 Registered Firm

Your Ref: Not yet allocated
Our Ref:
Email:
Date: 14 November 2012

Dear Sirs

Re: Claimant's Name: MR CHRIS FURLONG
Claimant's Full Address: [redacted]
Date of Accident: 1 November 2011

We are instructed by the above named to claim damages in connection with a personal injury which occurred on the 1 November 2011.

We have been informed that the Claimant is aware that their accident occurred on 1 November 2011, please confirm that you agree limitation in this instance will run three years from this date, i.e. that the limitation date is 1 November 2014.

We reserve the right to refer the Court to this correspondence in relation to the issue of limitation should it become necessary.

Please advise us as to the identity of your insurers, their address, the policy number and period of cover. Under the terms of the Civil Procedure Rules 1998 you have 21 days within which to do this. At the same time you must send the enclosed copy letter to your insurers. Failure to do so may affect your insurance cover and/or the conduct of any subsequent legal proceedings if you do not send this letter to them and they do not reply within 21 days.

To assist you and your insurers in investigating this claim we set out below the pre-action protocol information as follows :-

1. **Circumstances of the Accident**

On the day in question the claimant was walking along the public footpath behind Seaport train station, ... The lighting along the footpath was very limited. As the claimant was walking along the path, his left foot became caught in a pothole located on the pathway. The claimant fell forwards, landing heavily on his left leg. As a result the claimant sustained injury and loss.

2. **Allegations of Fault**

a. Causing or permitting the highway to become or remain in a dangerous defective condition.

b. Causing or permitting the highway to become or remain a danger and a trap to persons present there.

c. Failing to institute or enforce any or any adequate system of inspection of the highway whereby the hazard would have been detected and remedied before the claimant's accident.

d. Failing to fence, guard or warn the claimant of the hazard.

e. Failing to provide alternative means of access.

f. Failing to heed prior warnings of the hazard.

g. Causing the claimant foreseeable injury, loss and damage.

g. The claimant relies on breach of the Highways Act 1980 at Section 41 in that the highway was dangerous to persons using it.

3. **Details of Injuries**

The claimant sustained a fracture to his left tibia.

4. **Details of Losses**

The claimant's losses are to be confirmed.

5. **Hospital Details**

The claimant attended Seapoint Hospital

6. **Disclosure of Documents**

At this stage of our enquiries we would expect the documents contained in the attached schedule to be relevant to this action. Please ensure that these documents are retained by either you or your insurers as they will have to be produced and made available for our inspection in the event of there being a dispute as to liability.

7. **Nominated Expert**

Under paragraph 3.15 of the protocol we would suggest

Mr Zahir - Orthopaedic
Spire Roading Hospital, Roading Lane South, Illford, Essex, IG4 5PZ

Mr Am Rai - Orthopaedic
Hill House Consulting Rooms, BUPA Hospital Norwich, Old Watton Road, Colney, Norwich, NR4 7TD

8. Funding

Notice of Funding is enclosed.

Please note that the claimant is signed to a Conditional Fee Agreement with a Success Fee.

If you are aware of any Before The Event/ Legal Expense Insurance that will provide cover/ cost protection on behalf of our client we request that you immediately provide us with this information. Should this information come to your attention at anytime throughout the course of this claim please also provide us with this information. We reserve the right to refer this letter to the court on the question of costs should the need arise at the conclusion of this case.

In accordance with Pursuant to S35(2) of the Data Protection Act 1998, please provide us with your full name and address. Pursuant to S35(2) of the Data Protection Act 1998 states that personal information is exempt from non-disclosure provisions where disclosure is necessary.

Finally we would remind you of your obligation under the Pre-action Protocol to advise us within 21 days of the identity of your insurers and make sure that the copy letter is passed onto them so that they can also acknowledge it within 21 days.

Please note that if we have not heard from your insurers within 3 months and 21 days of this letter of claim, i.e. by 5 March 2013 we will have no alternative but to apply to the court for pre-action disclosure.

Yours faithfully,

Enc.

Notice of Funding
Fast Track Disclosure
Copy Of Letter Of Claim

FAST TRACK DISCLOSURE

HIGHWAY TRIPPING CLAIMS

Documents from the Highway Authority for a period 12 months prior to the accident;-

(i) Records of inspection for the relevant stretch of highway
(ii) Maintenance records including records of independent contractors working in relevant area
(iii) CCTV footage.
(iv) Records of the minutes of Highway Authority meetings where maintenance or repair policy has been discussed or decided.
(v) The Authority's policy documents and/or instructions to Inspectors on inspection and maintenance protocols and the criteria used for intervention levels
(vi) Records of complaints about the state of the relevant highway
(vii) Records of other accidents which have occurred on the relevant stretch of highway.
(viii) All documents relating to inspection procedures
(ix) All documents detailing methods of inspection (specifically detailing if the inspection is walked or driven)

In addition we require inspection records for the first routine highway inspection carried out at the locus after 1 November 2011.

Notice of funding of case or claim

Notice of funding by means of a conditional fee agreement, insurance policy or undertaking given by a prescribed body should be given to the court and all other parties to the case:

- on commencement of proceedings
- on filing an acknowledgment of service, defence or other first document; and
- at any later time that such an arrangement is entered into, changed or terminated.

In the Kingston upon Hull County Court The court office is open between 10 am and 4 pm Monday to Friday. When writing to the court, please address forms or letters to the Court Manager and quote the claim number.	
Claim No.	
Claimant (include Ref.)	CHRIS FURLONG
Defendant (include Ref.)	BEACH BOROUGH COUNCIL

Take notice that in respect of

☐ all claims herein

☐ the following claims

☑ the case of *(specify name of party)*

CHRIS FURLONG

[is now][~~was~~] being funded by:

(Please tick those boxes which apply)

☑ a conditional fee agreement

Dated 15/07/2012

which provides for a success fee

☐ an insurance policy issued on

Date **Policy no.**

Name and address of insurer

Level of cover

Are the insurance premiums staged?

☐ Yes ☐ No

If Yes, at which point is an increased premium payable

☐ an undertaking given on

Date

by

Name of prescribed body

in the following terms

The funding of the case has now changed:

☐ the above funding has now ceased

☐ the conditional fee agreement has been terminated

☐ a conditional fee agreement

Dated

which provides for a success fee has been entered into;

☐ an insurance policy

Date

has been cancelled

☐ an insurance policy has been issued on

Date **Policy no.**

Name and address of insurer

continued over the page ⇨

Level of cover

Are the insurance premiums staged?

☐ Yes ☐ No

If Yes, at which point is an increased premium payable

☐ an undertaking given on

Date

has been terminated

☐ an undertaking has been given on

Date

Name of prescribed body

in the following terms

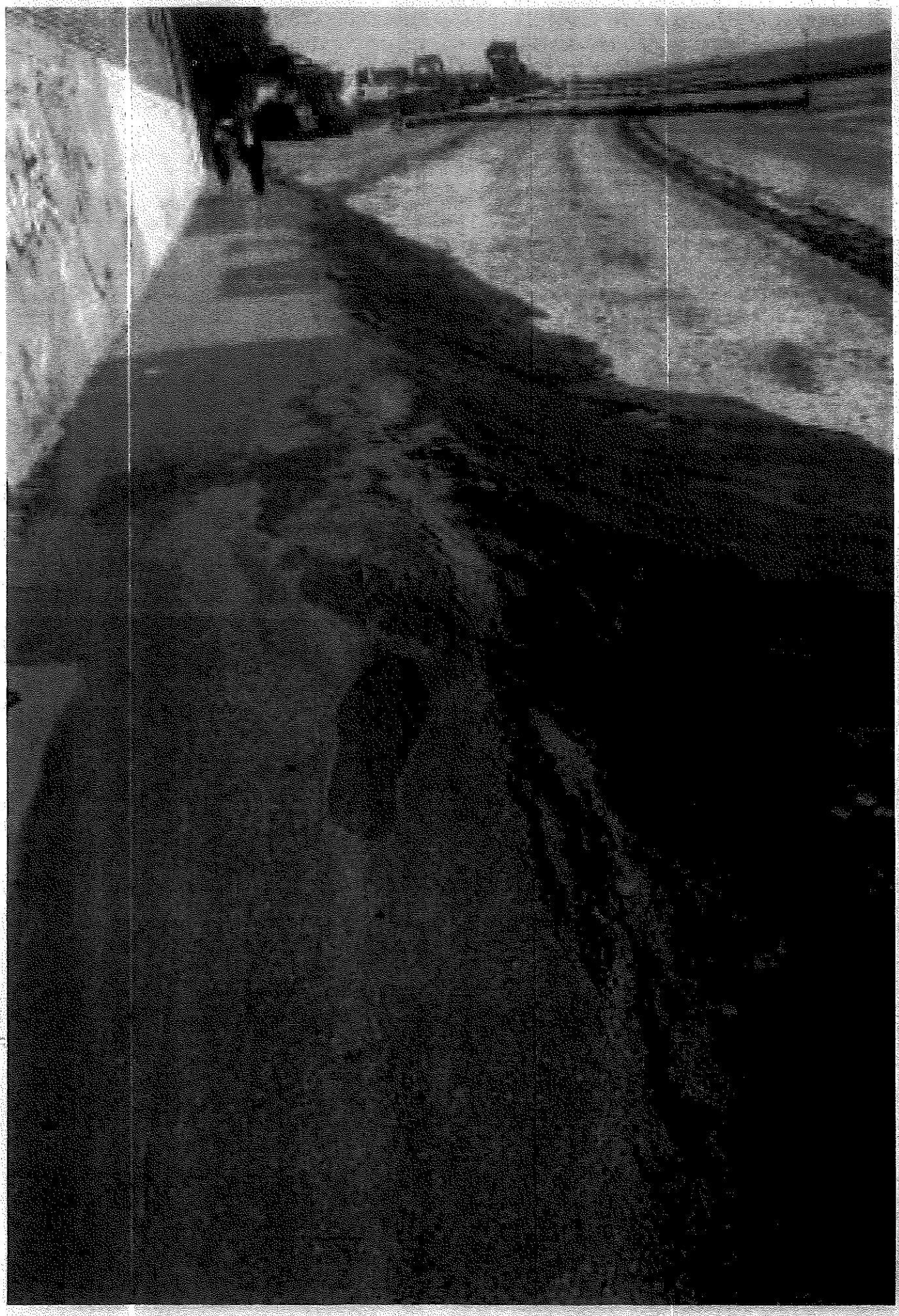
Signed

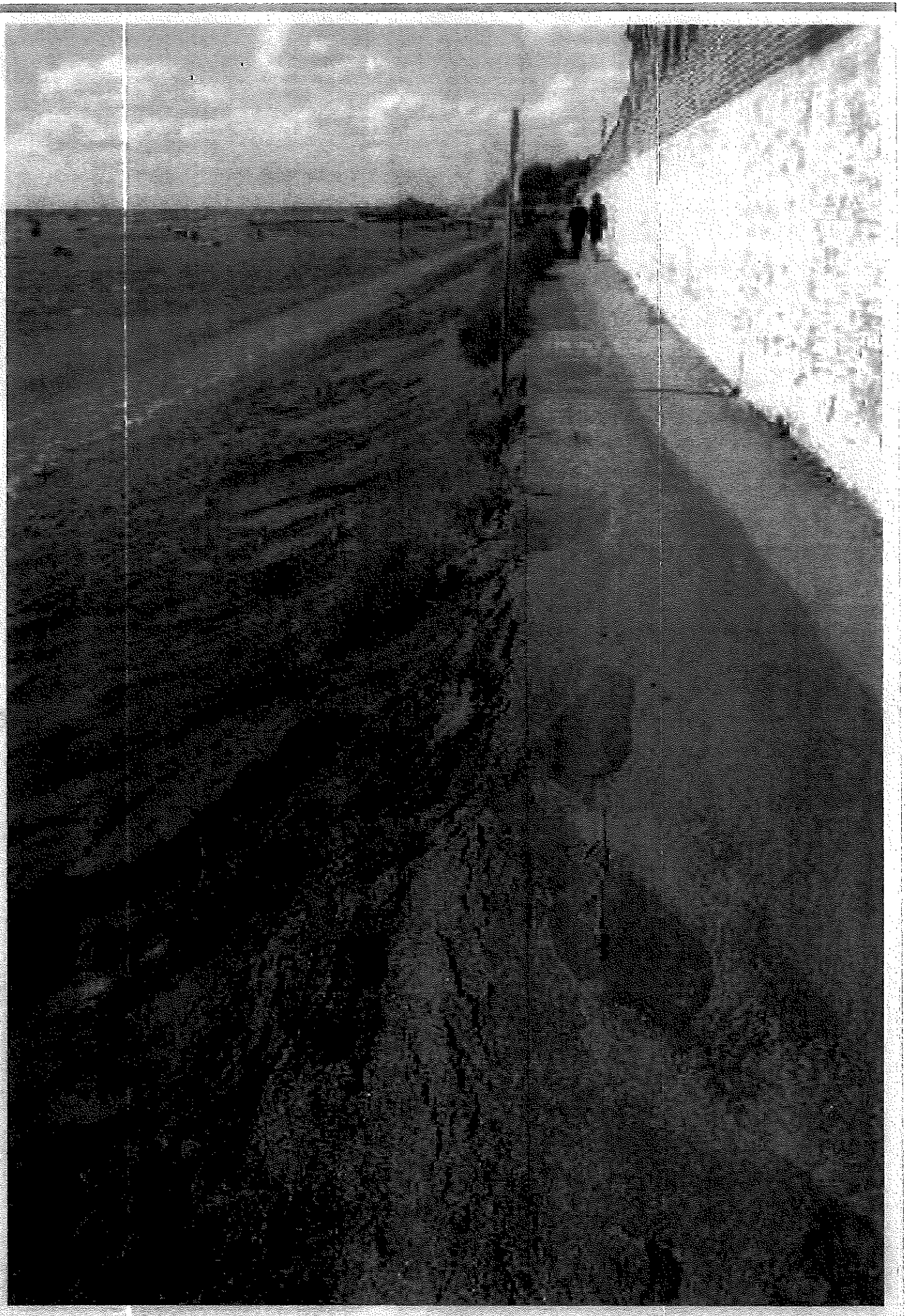
Rapid Solicitors

Solicitor for the (claimant) (~~defendant~~)
(Part 20 ~~defendant~~) (~~respondent~~) (appellant)

Dated

14/11/2012





Chris Furlong

Liability:

It is the Claimant's case that he tripped and fell on a significant pothole on the footpath behind Seapoint Train Station and which was poorly lit at the time, leading him then to fall a reasonable height onto a gravel slope running alongside thereby suffering a severely fractured left ankle. He had a witness with him at the time.

Notwithstanding there having been an inspection pre-accident on 7 May 2010 carried out in which it was indicated that there were no defects at the accident locus, it is noticeable that just 10 months later in an inspection carried out by a different Inspector on 14 July 2011 that a significant amount of defects were identified along the entire length of the footpath, all of which would appear to have been Category 1 defects. This inspection was 4 months before the Claimant's accident. Although Works Orders were requested for those repairs, it is unclear if they were carried out, and that particular inspection would appear to have only arisen as a result of public complaint. It is not clear as to whether or not those repairs were carried out because on 28 February 2012 (3 months post-accident) there was then another inspection when it would appear that an order for the same area of repairs was then made again and a computer printout dated 7 February 2013 indicates that "an alleged accident site marked by the rear of Seapoint Railway Station in October/November is still awaiting repairs". The post-accident report form refers to there then being a discussion a year post-accident in November 2012 as to the repairs that were required.

It would seem based upon the paperwork that there were significant Category 1 defects identified on the path in question that seemingly were not repaired and not repaired in good time and upon which the Claimant tripped and fell. It would seem these were not repaired at the date of the post-accident inspection of November 2012 either.

1. Made on behalf of: Claimant
2. Witness
3. Number of Statement: First
4. Exhibits: 0
5. Date of Statement: 15/3/15

IN THE COUNTY COURT

CASE:

MR CHRIS FURLONG

CLAIMANT

-V-

BEACH BOROUGH COUNCIL

DEFENDANT

WITNESS STATEMENT OF THE CLAIMANT

I, SAY AS FOLLOWS:-

1. I am the Claimant herein. My date of birth is 1 December 1956 I was involved in an accident on 1st November 2011. I was fifty five at the time of the accident.

2. My National Insurance Number is JC 20 40 20 A

3. At approximately 9:45pm on 1st November 2011 I was walking along the public footpath behind Seapoint Train Station in Beach I was with my stepson, Gareth The lighting along the footpath was very limited. As I was walking along the path, my left foot became caught in a pothole located on the pathway. I fell forwards, landing heavily on my left leg. I fell over the edge of the path and down onto an area of tarmac and debris,

adjacent to the path leading down to the foreshore beneath. I felt my ankle snap. It was obvious straight away that the injury was serious because of the swelling and the angle of my left foot I was not able to walk.

4. There was no signal for mobile phones, so Gareth had to leave me where I had fallen as he went to call for an ambulance. There was no access for the ambulance to get to where I had fallen, so it took quite a long time before they could get me up to where the ambulance was parked in the road above the station. I was taken by ambulance to St Waves Hospital, where it was found that I had suffered a pilon fracture to my left ankle, I also sustained some minor abrasions. I was admitted to St Waves Hospital While I was in hospital I was visited every day by my sons, Joe and Phil, my stepsons Gareth and Dave and also my stepdaughter, Nikki.

5. I had surgery on my left ankle on 8th November 2011, this was an open reduction internal fixation (ORIF). During the operation, screws and a locking plate were fixed into my ankle. Following the surgery, my ankle was placed in a cast.

6. I was then discharged from hospital on 10th November 2011. I was given painkillers as I was still in a lot of pain. I was given instructions to be non weight bearing on the left leg for 8 weeks following discharge. When I was discharged home, one of my sons or stepsons came over to stay with me so that there was always someone with me to help with shopping, tidying up, cooking, taking me out for some fresh air and generally helping me to get around. I would say that I needed help for about 2 hours a day after I was discharged from hospital until I was out of plaster. I probably needed help for an hour or so a day on average after that.

7. I returned to St Waves Hospital to have my stitches removed 2 weeks after the operation.

8. I was followed up at the outpatient clinic at St Waves Hospital on 20th December 2011. I was still non weight bearing on the left leg. The plaster cast had been uncomfortable and it was changed at that clinic for a lightweight cast.

9. I attended the outpatient clinic again on 10th January 2012 when the plaster was removed. My left ankle was stiff. It was recommended that I should have a course of physiotherapy. I was advised that there was a risk of arthritis developing in the left ankle.

10. I attended the outpatient clinic again on 28th February 2012. The left ankle was swollen and I was told it was a bad injury. Again I was advised that there was a risk of future osteoarthritis, secondary to the trauma to my left ankle. I was discharged from the outpatient clinic after this attendance.

11. I did not see my GP regarding the ankle injury until 15th April 2013 and again on 3rd May 2013 when I was prescribed Diclofenac anti inflammatory tablets.

Pre-accident History

12. I left school at the age of 16 with no qualifications in 1979. I worked on building sites doing general labouring work after I finished school.

13. When I was 18 I started working for British Rail in 1981 as a P-Way Trackman, doing track maintenance work. I did not need any qualifications for the job and all training was done on the job.

14. I worked for British Rail until 1988 and after that I continued doing track maintenance work but for other companies. One of these was Stirling Metro Rail. I also worked for other private companies but they are no longer in existence.

15. I began living with my former partner, Pamela (Pam) towards the end of the 1980's. Pamela had 3 children by a previous relationship, so I have one step-daughter and two step-sons. Pam and I had 2 sons together who were born in 1990 and 1991 and they are now aged 23 and 22. We brought up all 5 children together. I worked and Pam fulfilled the role of mother and "housewife", although we were never married.

16. My step-daughter, Nikki , was 5 years old when I started living with Pam. She is now in her mid 30's. Nikki is married to Daniel and they met at school so I have known Daniel since he was at school, when he would come to our house to see Nikki and they have a daughter and 2 sons, who are my grandchildren and they are aged 14, 9 and 6.

17. Daniel's father is Michael and in the early 1990's, probably around 1992, I started working as a fire protection fitter for Michael The work I did there was fitting smoke detectors, running cable to smoke heads, drilling channels to wire the smoke

heads up and pinning up the smoke heads. I would work from drawings. I would sometimes wire the smoke heads in, but then someone else would test them. I did the labour for the electricians. I worked for Michael for approximately 2 years until around 1994.

18. Between 1994 and 2002, I did various different jobs including a couple of factory jobs, some van driving work, some labouring work and I also did some kitchen fitting work for a company called Spacemakers. I also worked for different companies doing track maintenance work on the railways. I was often taken on as a contractor rather than being employed by these companies.

19. In 2002 I was employed by AMEC Rail to do the same type of track maintenance work I had previously done with British Rail and other companies. I worked from the depots at either Leigh on Sea or Barking and then going out on the track from the yard between Shoeburyness and Fenchurch Street. In around 2003, AMEC Rail changed its name to Network Rail and I continued working for Network Rail until the middle of 2007. Unfortunately, my relationship with Pamela had run into difficulties and we had been having problems for a few years before we split up altogether in 2007. I was short of money and I fell apart. I became depressed and I took some scrap metal belonging to Network Rail and sold it to a scrap metal merchant. Network Rail discovered this and I was prosecuted for theft and pleaded guilty. It was a one off incident and I had an exemplary disciplinary record up until then. I was given a community service order and a fine. I assisted Network Rail with the recovery of the scrap metal from the scrap metal merchants I had sold it to. I was dismissed from my employment with Network Rail as a result of this.

20. I earned £22,131.45 gross at Network Rail in 2004/2005, then £23,107.25 gross in 2005/2006. I earned £24,954.21 there in 2006/2007 and then £3,147.57 in 2007/2008 in the couple of months I worked there in that tax year prior to my dismissal.

21. I then became homeless in around December 2007 after I lost my job at Network Rail. I had to resort to staying with Dave and Gareth or with friends for a couple of weeks at a time, moving on elsewhere before I outstayed my welcome.

22 I did some work for Continental Shutters Limited in Basildon in around 2007 but I was not there for very long. I also did some work for Daniel doing the same fire protection

work I had done for his father, Michael , back in the 1990's. Daniel has worked in the fire protection business either for his father and his uncle or on his own account for years. David was usually the site foreman in the company. Michael also worked in the business together with his brother. They generally worked in two teams in pairs. The company name has changed several times. I remember it being called Martin Fire Protection and also Faircroft Fire Protection and there have been other variations on those names. David ran a company called Capital Fire Solutions. The availability of work depended on what jobs David and Michael had on.

23. I managed to get a rented flat in Leigh on Sea in around 2008 or 2009 and things started to get better for me. I remained at that flat for 3 years until several months after my accident in November 2011. I had to leave as the landlord was selling the flat.

24. I worked for VG Clements Contractors Limited in around late 2008 until August 2010. They are railway contractors on the London Underground and I did track maintenance work for them as a contractor whenever it was available. In the tax year 2008/2009 I earned £6,249.34 gross at VG Clements (Contractors) Limited and in the tax year 2009/2010 I earned £10,198.05 there. In 2010/2011 I earned £466.35 there.

25. I was not working at the time of the accident on 1st November 2011 but Daniel and Michael had offered me fire protection work starting in January 2012 for a 2 year contract which they had starting. I believe David was trading as Capital Fire Solutions at the time and Daniel was trading as Faircroft Fire. As far as I was concerned, the job was for David and Michael I was not concerned which of their company trading names would be used for the job. As explained above, I have known David since he was a teenager and as he is married to my stepdaughter, I regard him as my son in law. I have known Michael for over 20 years having worked for him in the early 1990's. This was to be a full time permanent position for 2 years and would have involved 40 to 50 hours work per week, for which I would be paid £500.00 per week. I was unable to start this work because of the injuries I sustained in the accident. David and Michael took someone else on to do the work in my place.

26. The majority of the work that I did prior to my accident was railway track maintenance. I had periods of unemployment from time to time, but for the majority of the time, I was working prior to my accident.

Pre accident medical history

27. When I was in my 30's I had a couple of episodes of black outs. This was investigated and I was told I had a low heart rate. I had another episode of fainting and dizziness in 2007 and again in July 2011. However, I am not required to take medication for any heart condition and I have not had any treatment other than the investigations which indicated I had a low heart rate. I had hernias in 1995 and 2000, possibly due to the heavy manual work I did on the railways. I was unemployed for a few months in the early part of 2002 and I saw my GP for depression in March 2002 as a result. I suffered from depression during the breakup of my relationship with Pamela and following the loss of my job at Network Rail. I was prescribed Citalopram in December 2007 for that. Things improved during the early part of 2008 when I found somewhere to live and subsequently found some work, so that I had some money coming in.

28. Other than as stated above, I had no medical treatment prior to the time of my accident on 1st November 2011.

Present Condition

29. I have little or no movement in the ankle at all and because of that I have problems with my balance. I am still taking painkillers. I use Paracetamol, but I also have prescription medication which is currently Certraline and Zapain. I also take Citalopram for depression.

30. I use crutches most of the time if I go outside. I cannot bend my left foot at all. I might just use one crutch if I do not have too far to go, but if I am going any distance, I use two crutches. I can walk without them, but it is painful and I am scared of falling over.

31. I have a feeling of tightness in the ankle and foot, I tend to put virtually all of my weight on my right side and I get pain in my back which I think is because of this. My foot tightens up if I am sitting down or lying down for a period of time. My foot and ankle are worse in cold weather.

32. I am not able to play with my 3 grandchildren as I would like to and as I used to before the accident. I am not able to ride a bike which I also did prior to the accident. I have a

full driving licence but I do not have a car. I do not think I would be able to drive a manual car, but I might be able to drive an automatic car if I had one. I use taxis or travel by bus. I prefer to avoid using buses on my own if I can because of concern about falling over, so I try to have someone with me if I travel by bus. I used to enjoy walking my dog prior to the accident but I was not able to cope following the accident and the dog had to go.

33. I have wasting of the muscle in my left calf. I have a scar on my shin. My left leg feels cold and looks red below the knee.

34. My left ankle is swollen and I have scars on both sides of the ankle. I still need some assistance from my family whether it be my sons, stepsons or my stepdaughter. The main thing I need assistance with now is general help getting around. It is reassuring to have someone with me if possible when I go out because of the problems with my balance and my fear of having a fall.

35. I refer to the medical reports of Mr K P Sherman, Consultant Orthopaedic Surgeon, dated 5th December 2013, 13th June 2013 and 6th December 2014 for further details of my treatment and medical condition. I also refer to the medical reports of Dr C A Jenner, Consultant in Pain Medicine, dated 7th October 2014 and his recommended treatment plan of the same date. Both Mr Sherman and Dr Jenner recommend a referral to a Pain Clinic and I confirm that I do want to have pain management treatment and rehabilitation.

36. As explained above, I had to move out of my rented accommodation several months after my accident towards the middle of 2012. I was unable to work and so I had problems finding alternative accommodation. I went back to living with family again including staying with Nicki and Daniel and also with my son. I obtained temporary accommodation in Wickford Hostel, but I was made homeless from there and went back to living with my son again. I obtained temporary accommodation again in Ryland's Hostel, but was again made homeless from there. On each occasion, I am told I am not in priority need of accommodation. At present I am living at my sons.

37. I think it is unlikely that I will be able to work again as a result of the injuries sustained in the accident because of the problems I have with mobility, balance and pain. Standing and walking makes the pain worse. I have problems climbing ladders and stairs.

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true.

Signed.....

Dated this day of 2015

Case No. A30YM261

BETWEEN

Claimant

MR CHRIS FURLONG

-and-

BEACH BOROUGH COUNCIL

Defendant

WITNESS STATEMENT

Name of person Mr Jeff furrow
giving statement:

Statement Number: First

Signed the:

Name:

Address:

Occupation: Insurance Administration Assistant

1. I make this statement to assist the Defendant in the defence of a claim for personal injury arising out of an alleged tripping accident on 1 November 2011.

2. I work for Beach Borough Council in the Insurance Department as an Insurance Administration Assistant and which is a role that I have held for [10] years.

3. On 24 April 2015 at exactly 9.30am I received a call from a member of the public. A word for word transcription of that call, is attached to this witness statement for the Court to review as Exhibit "OH1".

4. As the Court will note, on my having greeted the caller, the caller informed me that he wished to report a fraudulent claim.

5. As is detailed in Exhibit "OH1", he then went on to state that the fraudulent claim involved the Claimant in this matter, a Mr Chris Furlong and that the accident did not happen in the way in which the Claimant has suggested by way of his tripping on an unlit towpath behind the railway station but rather as a result of him having tried to "jump" the train and having fallen when doing so.

6. The caller in question indicated seemed to know a lot about the Claimant's case, not only the basis upon which the accident he said happened, but also as to a possible value of the claim, about how the Claimant has said that he was/is homeless and even that the Claimant was accompanied by Gareth when he apparently had the said accident which is something only revealed as I understand matters in the

Claimant's witness statement. He told me that the claim was entirely fraudulent and based upon a lie and that the Claimant had no train ticket and was attempting to "jump" the train (ie get on it without a ticket by jumping over a fence) when he fell and suffered the injury concerned. He also indicated that Gareth was apparently not in agreement with this claim.

7. I tried to push him to confirm who he was but he refused to say and instead only repeated that it was a fraudulent claim and that he did not feel it was right that the Claimant could potentially be in receipt of damages to the extent referred to, when the claim is not true.

8. I immediately made a note of the conversation and which is then detailed as per the Exhibit attached.

9. I believe that the facts stated in this Witness Statement are true.

SIGNED: .....

DATED this day of May 2015

Case No. A30YM261

BETWEEN

MR CHRIS FURLONG — Claimant

-and-

BEACH BOROUGH COUNCIL — Defendant

WITNESS STATEMENT

Name of person giving statement: Ms Natalie Ayres

Statement Number: First

Signed the:

Name:

Address:

Occupation: Senior Insurance Officer

1. I work for BEACH BOROUGH COUNCIL and make this statement in support of the defence of a claim for personal injury arising out of an alleged accident on 1 November 2011.

2. I have worked at BEACH BOROUGH COUNCIL for [6] years and work as a member of the insurance team responsible for investigating and responding to (amongst others) claims brought by members of the public such as highway tripping claims.

3. On 6 June 2015 4:30 pm I was at work when I received a call from a member of the public who wished to speak with me about the claimant's claim.

4. I am aware that my colleague Jeff previously received a call from a member of the public informing us that the claim in question was fraudulent and I believe it was the same caller ringing for a second time as the information that he gave was very specific and mirrored what we were aware that he had told Jeff previously.

5. He told me that the claimant's case was fraudulent saying that apparently he suffered injury when he tried to "jump" the train at Seapoint train Station. He told me that Gareth was with the claimant at the time of

the accident which is something obviously only the claimant would know and as stated in his witness statement. He said we should speak to Gareth as a result. He seemed to imply that the claimant had encouraged Gareth to similarly bring a fraudulent claim but that Gareth did not want to be involved. He also told me that claimant had recently been to see medical experts and apparently was boasting that as a result of his having "jumped" the train and not paid for a train ticket he was now going to be paid by the Local Authority upwards of £70,000.

6. In light of the importance of this call I did ask the caller in question twice to confirm his name or contact details or in the alternative to provide Gareth but he did not do so.

7. Attached to this witness statement as exhibit MW1 is a typed summary of the conversation that I made within minutes of the call finishing with him on 6 May.

8. I believe that the facts stated in this Witness Statement are true.

SIGNED: .....

DATED this day of May 2015

ML Expert Consulting
Harley Street

MEDICAL REPORT

Dr C A Jenner MB BS FRCA FFPMRCA
Consultant in Pain Medicine
London Pain Clinic

ML Expert Consulting Ltd
Fairview, Parkhill
Whitecroft, GL15 4PQ
0207 118 1134 (1000-1700 hrs)
jamos@mlecl.com

Date:	7 October 2014
Claimants Personal Details:	Mr Chris Furlong
Date of Birth:	
Date of Index Accident/Incident:	1 November 2011
Examination Date:	18 August 2014
Instructions Received From:	Rapid Solicitors 878 Beverly Road Hull HU6 7DQ
Instruction Reference:	JB/HH/30352321703.12

CONTENTS OF REPORT

1. INTRODUCTION

1.1 Author:

My name is Dr Christopher Jenner. I am a Consultant in Pain Medicine at the Imperial Healthcare NHS Trust where I have been a Consultant since 2003 working in both the Pain Clinic and the Department of Anaesthesia. I trained in Anaesthesia and Pain Medicine as a Specialist Registrar on the North West Thames Specialist Registrar Training Programme and received my CCST (Certificate of Completion of Specialist Training) in 2003. I have been involved in a number of medicolegal cases including medicolegal assessments, medical insurance company assessments and reporting for government agencies including The Department of Health, as well as local housing authorities. For further information, please refer to my CV which has been included at the end of this report.

1.2 Details of Assessment:

The assessment consultation was carried out on 18 August 2014 at Harley Street, London. I identified Mr Furlong by means of inspection of:

- Driving license
- Head and shoulder shot taken at examination

Copies of identification documents can be found at Appendix C.

1.3 Documentation Seen:

A number of documents were viewed including all provided to me from the below:

- Hospital records
- General Practitioner records
- Medical report of Mr Sherman, Orthopaedic Consultant.

Some of these documents may have been handwritten or are difficult to read, and therefore dates, names and other information contained therein have been reported to the best of my ability in interpreting these correctly.

There may of course be in existence further medical records or entries that I have not been made aware of at this time. This report is therefore based purely on those records of which I have been made aware.

2. INSTRUCTION

2.1 Instructions Received:

This report is prepared for the court on the instructions of Rapid Solicitors.

2.2 I have been asked to respond to the following instruction and comment specifically on the following points in this report:

It has been identified that the Claimant has developed Complex Regional Pain Syndrome as a result of the accident.

2.2.1 We would be obliged if you would examine the Claimant and let us have a full and detailed report dealing with any relevant pre-accident medical history, the injuries sustained, treatment received and present condition, dealing in particular with the capacity for work and giving a prognosis.

2.2.2 It is central to our assessment of the extent of the Claimants injuries to establish the extent and duration of any continuing disability. Accordingly, in the prognosis section we would ask you to specifically comment on any areas of continuing complaint or disability or impact on daily living. If there is such continuing disability you should comment upon the level of suffering or inconvenience caused and, if you are able, give your view as to when or if the complaint or disability is likely to resolve. If you recommend any further investigations or treatment, please provide us with costings in respect of these.

2.3 Additional references/literature

Under CPR 35 I have considered the range of opinion and outlined the reasons for my own opinion. Any literature I deemed relevant and relied upon for the preparation of this report is listed in Appendix B.

3. HISTORY

3.1 The circumstances of the accident are that on the day in question the Claimant was walking along the public footpath behind Seapoint train station, Beach. The lighting along the footpath was very limited. As the Claimant was walking along the path, his left foot became caught in a pothole located on the pathway. The Claimant fell forwards, landing heavily on his left leg.

3.2 As a consequence of the accident the Claimant sustained a fracture to his left tibia, requiring pins and plates.

4. PRE-ACCIDENT/INCIDENT MEDICAL RECORDS

4.1 Mr Furlong's Records dated 26 March 2002 documented depressive episode, suicidal ideation.

4.2 Mr Furlong GP Records dated 6 December 2007 documented depressive episode.

5. POST-ACCIDENT/INCIDENT MEDICAL RECORDS

5.1 On 1 November 2011 East of England Ambulance Service report recorded that Mr Furlong was walking along an unlit towpath when he feel down a slipway. He felt his ankle snap. There had been immediate swelling and deformity. He was unable to walk. A bandage was applied to help the 'hanging off' sensation. There was a delay because the towpath had no access available. The diagnosis was ?fracture of left ankle.

5.2 Mr Furlong presented to A&D Department, Seapoint Hospital on 1 November 2011 with query fracture of left ankle and was seen by Dr M Shittu. He was walking along an unlit footpath when he lost his footing in a dip in the ground and sustained injury to his left ankle. There was swelling, deformity and marked tenderness of the ankle. There was no neurovascular deficit. He was diagnosed to have left ankle fracture.

5.3 On 1 November 2011 Mr Furlong had x ray the left ankle. The report read, "There are intraarticular fractures of the distal tibia and distal shaft of the fibula with marked comminution and displacement of the fracture fragments".

5.4 On the same day Trauma and Orthopaedic Department recorded, "Fell off wall, 2 feet high, twisted ankle on landing, ?everted, pain and swelling immediately. H/o Depression, arthritis. Backslab, likely will need ex-fix. Lot of pain, distressed. Comminuted left ankle fracture". He was admitted to the hospital.

5.5 On 2 November 2011 Mr Furlong was seen by SHO Harris who noted, "ATSP as pain suddenly increased, swollen, decreased sensations all distributions. Pain on passive dorsiflexion felt in ankle. I am unsure if this is compartment. Numbness n left foot, particularly plantar aspect. Foot and lower leg elevated on a Brauns frame and icepacks applied to reduce swelling". On the same day evening it was recorded that compartment syndrome was unlikely.

5.6 On 3 November 2011 Mr Furlong complained of pain and pins and needles sensation. Oromorph was given for breakthrough pain.

5.7 On 8 November 2011 Mr Furlong underwent ORIF distal tibia/fibula (pilon) fracture by surgeons A Khan and Mr Raza. A calcaneal pin traction was applied. Lateral approach was made to the fibular and the fibular fracture was fixed with a plate. Tibial fracture was comminuted. It was reduced and stabilised with AP cannulated screws and medial locking plate. Plaster of Paris backslab was applied.

5.8 A Discharge Summary from Seapoint Hospital dated 10 November 2011 recorded that Mr Furlong presented to hospital after falling from a height. He sustained a fracture to his left tibial plafond. He underwent ORIF. He was to be non-weightbearing on the left side for 8 weeks. Paracetamol, codeine phosphate and Diclofenac were prescribed.

5.9 On 20 December 2011 Mr A Kapoor, FRCS, Specialty Doctor in Orthopaedics, Seapoint Hospital recorded that 6 weeks following surgery Mr Furlong was making steady progress. He continued to be non-weightbearing. The plan was to provide a light weight cast as his cast was uncomfortable. He was advised strict non-weightbearing for 2-3 weeks.

5.10 On 10 January 2012 Mr A N Khan, FRCS (Tr&Orth), MSc Orth, Consultant Orthopaedic Surgeon, Seapoint Hospital recorded that Mr Furlong had the plaster for left distal tibia/fibula intra-articular fracture with internal fixation removed. The ankle was stiff as expected. Ankle physiotherapy was arranged. He was informed about the likely changes of ankle arthritis in the long run.

5.11 In a referral letter to Physiotherapy Department, Seapoint Hospital dated 28 February 2012 Mr A Zaidan, MRCS, Staff Grade in Orthopaedics requested a review of Mr Furlong following ORIF of left ankle for pilon fracture.

5.12 On 1 March 2012 Mr Furlong attended clinic with Mr Zaidan who noted that he was mobilising partially weight bearing using two crutches. The ankle was swollen with limitation of movement which was expected with the type of bad injury that he had. He was warned about future osteoarthritis secondary to trauma. He was told that the swelling would take few months to settle and he should work on his ankle with the help of physiotherapy.

5.13 On 7 March 2013 Dr Taz Syed, GP recorded that Mr Furlong suffered with depressive episodes in the past. He had fracture of tibia and fibula with operative repair. He was suspected to be a vulnerable adult.

5.14 Mr Furlong GP Records dated 18 March 2013 noted that he had newly registered with the practice.

5.15 Mr Furlong GP Records dated 15 April 2013 documented, "Sustained #Lt ankle 1.11.11, been to Seapoint still walks on crutches. O/E Limited mvts to medial + lat side, large scar lat aspect lt ankle. Ref to community musculoskeletal service".

5.16 Mr Furlong GP Records dated 3 May 2013 documented, "Tibia fracture, osteosynthesis. O/E Swollen, not good result. Ref to orthopaedic, ?metal problem". Diclofenac and anti-inflammatory tablets were prescribed.

5.17 A Medical Record dated 5 December 2013 is prepared by Mr K P Sherman, BM CCh MA FRCS PhD, Consultant Orthopaedic Surgeon.

5.17.1 As a result of accident on 1 November 2011, Mr Furlong sustained a severe fracture involving his left ankle. The comminuted displaced intra-articular fracture was treated operatively. He continued to experience pain and swelling in the ankle. He also experienced tightness in ankle and foot, which were worse in cold weather. The pain was worst over medial and lateral aspect of the ankle.

5.17.2 On examination there was tenderness at the tip of left fibular head. Left calf circumference was 3.5 cm less than the right. There was severe wasting of calf muscles. The left leg was cold and red distal to the knee. There was easily visible swelling of left ankle and the circumference was 2 cm greater than right. There was pigmentation over the postero-medial aspect of the ankle. There was pronounced tenderness distal to the medial and lateral malleoli and along the anterior joint line of the ankle. The ankle was fixed in 10 degree of equines. There was only few degrees of movement in the subtalar joint. Mid tarsal movements were restricted to approximately 20% of normal. Dorsiflexion of the first metatarsophalangeal joint was restricted to 60 degrees. The restriction

of movements in the ankle and foot was thought to be permanent because of which he would experience difficulty walking on uneven surfaces.

5.17.3 Mr Sherman felt he would remain permanently restricted in his walking and climbing ability. It was probable that Mr Furlong developed post-traumatic osteoarthritis in the ankle as a result of the injury. New x rays of the ankle were recommended for confirmation. Mr Sherman thought he might have developed Chronic Regional Pain Syndrome given the discolouration of left leg and alteration of skin temperature and suggested further treatment. He was of the opinion that Mr Furlong would be left with permanent disability as a result of the index injury. If osteoarthritis was confirmed with x rays, arthrodesis of ankle would improve the equines deformity and result in marked improvement of pain but warned that it would abolish the remaining movement of the ankle. A referral to Pain Clinic was recommended. Mr Sherman believed that he would remain at a permanent significant disadvantage on the open labour market as he was unable to obtain paid employment since the accident.

5.18 On 7 May 2014 Mr Furlong had an x ray AP lateral view of the ankle which was interpreted by Dr F Alyas, Consultant Radiologist. The report read,

- "Commuted pylon and posterior malleolar intraarticular fracture of the distal tibia fixed with screw and plate and has healed. There is probable articular step towards the lateral side. There is valgus angulation at the tibia distal to the proximal fragment.
- Healed previous Webber type C fracture of the fibular fixed with screw and plate. There is slight flexion deformity and valgus deformity of the distal fragment.
- There is subtle subcortical and periarticular osteopenia suggestive of reflex sympathetic dystrophy or disuse osteopenia".

6. PAIN HISTORY

6.1 Site of the Pain:

- Left ankle.

6.2 Character of the Pain:

This is described as follows:

- Sharp

6.3 Pain Onset:

The pain started following the index accident on November 1 2011

6.4 Duration of the Pain:

This is described as daily.

6.5 Pain Radiation:

There are no radiations to the pain.

6.6 Aggravating Factors:

The pain is aggravated by the following:

- Standing.
- Walking.

6.7 Relieving Factors:

The pain is relieved by the following:

- Keeping elevated.

6.8 Medication:

is currently on the following medication:

- Paracetamol.
- Codeine.
- Diclofenac.

6.9 Investigations for Pain:

has undergone:

- X rays.

6.10 Other Symptoms Associated with the Pain:

reports the following:

- Stiffness in the ankle.

7. SUBJECTIVE MEASUREMENTS OF PAIN & DYSFUNCTION

7.1 These forms are sent to the patient for their completion, prior to their assessment

Brief Pain Inventory:

	QUESTION	ANSWER
1	Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains and toothaches). Have you had pain other than these every day kinds of pain?	No
2	On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.	Please see diagram
3	Please rate your pain by circling the one number that best describes your pain at its **worst** in the last 24 hours. (*0 - no pain / 10 – pain as bad as you can imagine*)	7/10
4	Please rate your pain by circling the one number that best describes your pain at its **least** in the last 24 hours. (*0 - no pain / 10 – pain as bad as you can imagine*)	0/10
5	Please rate your pain by circling the one number that best describes your pain on the **average.** (0 - no pain / 10 – pain as bad as you can imagine)	7/10
6	Please rate your pain by circling the one number that tells how much pain you have **right now.** (0 - no pain / 10 – pain as bad as you can imagine)	7/10
7	What treatments or medications are you receiving for your pain?	Please see previous section
8	In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much **relief** you have received. (*0% - no relief / 100% - complete relief*)	Not answered

9	Circle the one number that describes how, during the past 24 hours, pain has interfered with your: (0- does not interfere / 10 – completely interferes)	[redacted]
A	General activity	4/10
B	Mood	5/10
C	Walking ability	2/10
D	Normal work (includes both work outside the home and housework)	3/10
E	Relations with other people	8/10
F	Sleep	2/10
G	Enjoyment of life	5/10

7.2 S-LANSS Pain Score:

Leeds Assessment of Neuropathic Symptoms and Signs (self-completed):

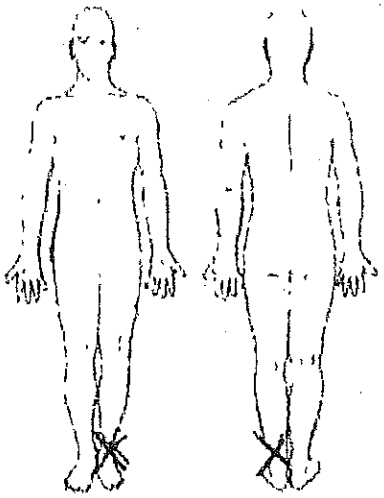
The Leeds Assessment of Neuropathic Symptoms and Signs (LANSS) Pain Scale[1] has seven items consisting of five symptom items and two examination items. Usually, the examination items are done by a doctor but the modified version (the S-LANSS or self-report LANSS) allows people to do this themselves. The purpose of these scales is to assess whether the pain that is experienced is predominantly due to nerve damage or not. Both the LANSS and S-LANSS are scored out of 24; a score of 12 or more is strongly suggestive of neuropathic pain. Please note, however, that although the S-LANSS is a useful guide to the type of pain, it should only be viewed as an indicator, and not as a diagnosis.

NAME: DATE: 16 August 2014

- This questionnaire can tell us about the type of pain that you may be experiencing. This can help in deciding how best to treat it.

[1] Source. Bennett, M et al The Journal of Pain, Vol 6, No 3 March , 2005 pp 149-158 The S-LANNS Score for Identifying Pain of Predominantly Neuropathic Origin Validation for Use in Clinical and Postal Research The Journal 3

- Please draw on the diagram below where you feel your pain. If you have pain in more than one area, **only shade in the one main area where your worst pain is.**



On the scale below, please indicate how bad your pain (that you have shown on the above diagram) has been in the last week (where '0' means no pain and '10' means pains as severe as it could be).

NONE 0 1 2 3 4 5 6 7 8 9 10 SEVERE PAIN

Below are 7 questions about your pain (the one in the diagram).

Think about how your pain, as you have shown in the diagram, has felt **over the last week.** Put a tick against the descriptions that best match your pain. These descriptions may, or may not, match your pain no matter how severe it feels.

- Only circle responses that describe your pain.

1. In the area where you have pain, do you also have 'pins and needles', tingling or prickling sensations?

a) NO - I don't get these sensations *(0)*
b) YES - I get these sensations often (5)

2. Does the painful area change colour (perhaps looks mottled or more red) when the pain is particularly bad?

a) NO - The pain does not affect the colour of my skin (0)
b) YES - I have noticed that the pain does make my skin look different from normal *(5)*

3. Does your pain make the affected skin abnormally sensitive to touch? Getting unpleasant sensations or pain when lightly stroking the skin might describe this.

a) NO - The pain does not make my skin in that area abnormally sensitive to touch *(0)*
b) YES - My skin in that area is particularly sensitive to touch (3)

4. Does your pain come on suddenly and in bursts for no apparent reason when you are completely still? Words like 'electric shocks', jumping and bursting might describe this.

a) NO - My pain doesn't really feel like this *(0)*
b) YES - I get these sensations often (2)

5. In the area where you have pain, does your skin feel unusually hot like a burning pain?

a) *NO - I don't have burning pain.* *(0)*
b) YES - I get burning pain often. (1)

6. Gently rub the painful area with your index finger and then rub a non-painful area (for example, an area of skin further away or on the opposite side from the painful area). How does this rubbing feel in the painful area?

a) *The painful area feels no different from the non-painful area.* *(0)*
b) I feel discomfort, like pins and needles, tingling or burning in the painful area that is different from the non-painful area. (5)

7. Gently press on the painful area with your finger tip then gently press in the same way onto a non-painful area (the same non-painful area that you chose in the last question). How does this feel in the painful area?

a) *The painful area does not feel different from the non-painful area* *(0)*
b) I feel numbness or tenderness in the painful area that is different from the non-painful area. (3)

Scoring: a score of 12 or more suggests pain of a predominantly neuropathic origin

SCORE for : 5/24.

8. TREATMENT FOR PAIN

8.1 **Introduction:** Mr Furlong has had some treatment for pain. This has included the following treatments.

8.2 **Medication:**
He is currently on a regime of prescribed pain medications, as outlined in section 6.8 Medications for Pain.

8.3 **Physiotherapy:**
Nil.

8.4 **Alternative Medicines:**
Nil.

8.5 **Minimally Invasive Pain Management Procedures:**
Nil.

8.6 **Surgical Treatments:**
Yes.

8.7 **Advanced Pain Management Techniques (Including spinal cord stimulators/intrathecal pumps):**
Nil.

9. EMPLOYMENT & ACTIVITIES OF DAILY LIVING

9.1 The below effects are as reported to me by Mr Furlong. The account of the employment and activities of daily living is therefore purely subjective in his opinion and representation to me.

9.2 Working Life:

Mr Furlong reports that at the time of the index accident he was not working, however, he had the opportunity to work as a Fire Protection and Smoke Alarm Fitter with a family members company, but unfortunately due to the index accident he has been unable to take up this role. He believes his career has been affected.

9.3 Home Life:

Mr Furlong reports that his ability to carry out day-to-day tasks has been affected. He has needed additional support at home due to the accident. His hobbies have been affected.

9.4 Relationships:

Mr Furlong reports that he does not engage much in social activities. Luckily the accident did not have any effect on his relationships.

10. EXAMINATION

10.1 Assessment Consultation:

The assessment consultation for Mr Furlong was carried out on 18 August 2014 at Harley Street, London. The techniques used included inspection, palpation and neurological examination.

- **Inspection** is the visual examination of the body with a lighted instrument if needed.
- **Palpation** is the examination of the body using touch.
- **Neurological examination** includes sensory and motor testing for light touch, pinprick sensation, tone, power and reflexes.

10.2 General Inspection:

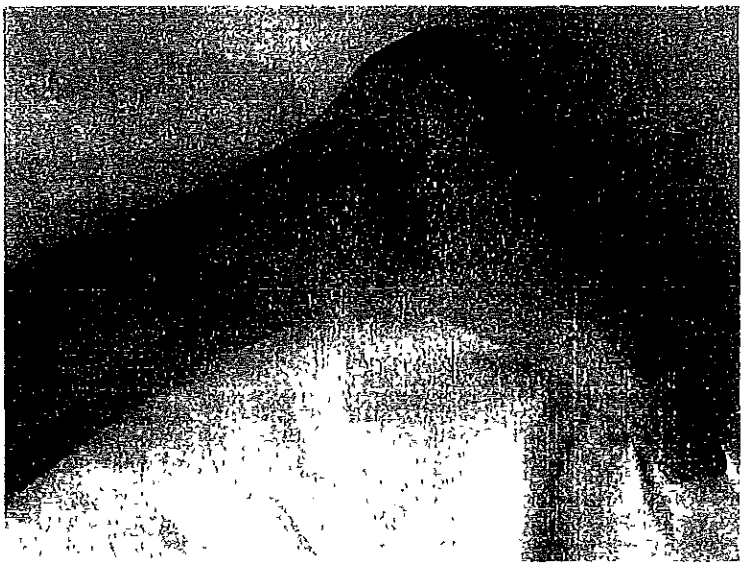
- Walking with 2 elbow crutches.

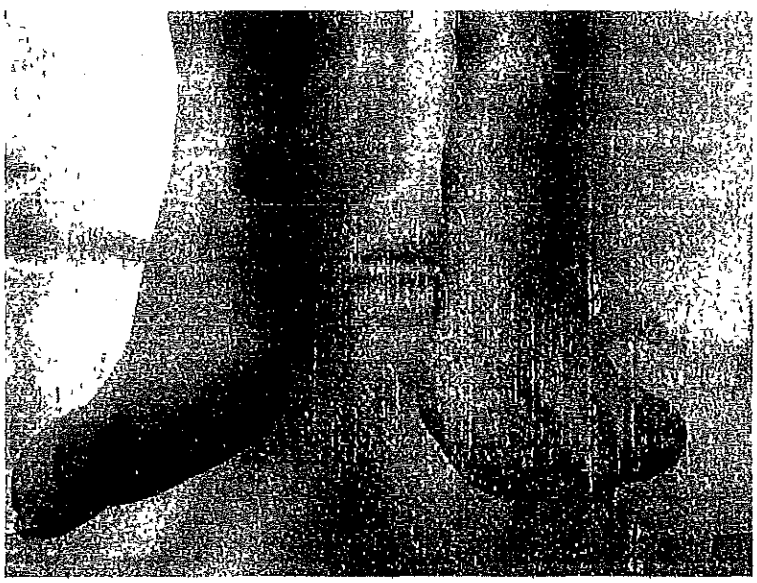
10.3 Site: Left Lower Limb.

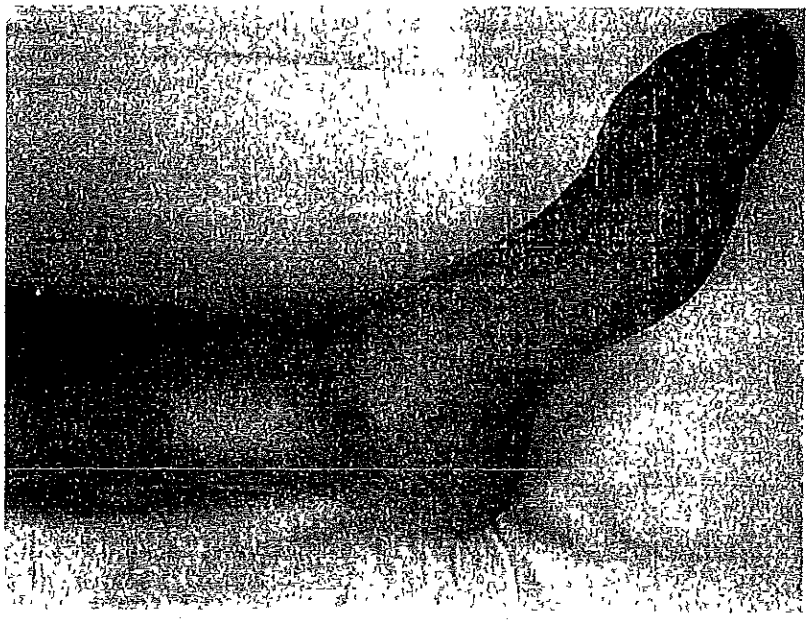
- **Inspection:**
  - Well-healed surgical scars noted.
  - No colour changes.
  - Some swelling of the left medial malleolus.
  - Global reduction in the range of movement of the ankle joint secondary to pain.
  - No change in hair growth.
  - No change in nail growth.
  - Reduction in swelling of superficial veins in the left foot and ankle compared with the right.

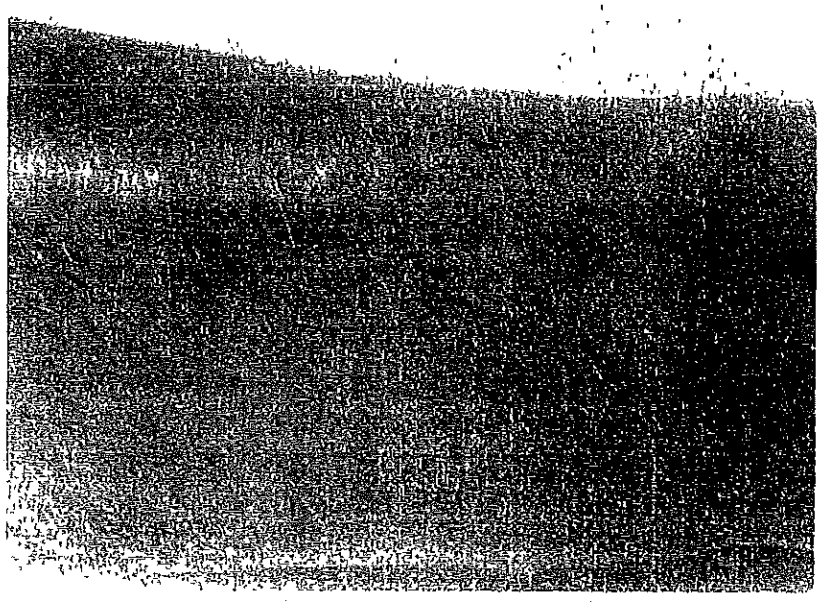
- Palpation:
    - Notable difference in temperature between the left foot and ankle and the right – left foot and ankle markedly colder to touch.
    - Foot pulses present.
    - Capillary refill less than 3 seconds.
    - Reduction in pressure, in particular the left anterior aspect of the foot.
    - Normal light touch sensation.

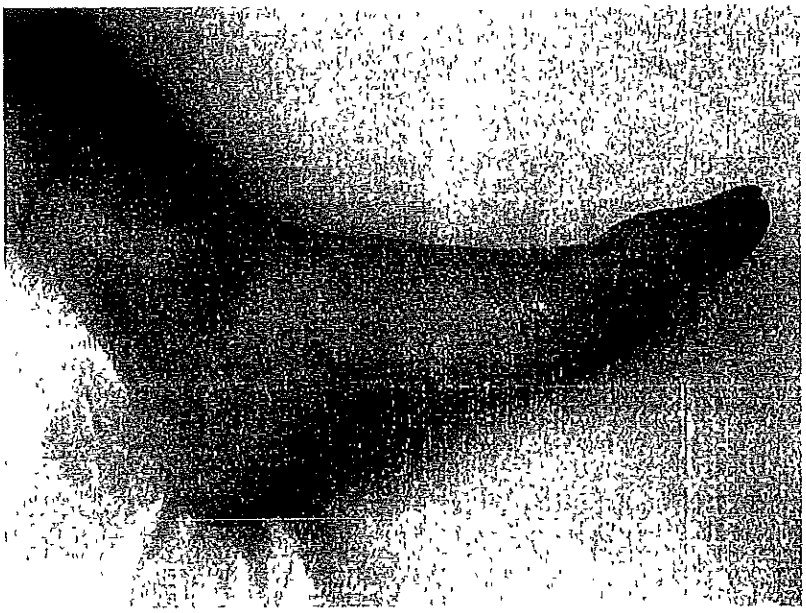
- Patient Comments:
  Mr Furlong described the following:
    - Intermittent left foot and ankle swelling, especially in the left medial malleolus.
    - Intermittent colour changes, including intermittent dark red discolouration.
    - Pain described as a vice-like pain surrounding the left forefoot.
    - Some pain in the left distal lower leg at the site of operative intervention.
    - Metalwork in situ, including 4 pieces of metalwork and approximately 40 screws.
    - No change in hair or nail growth.

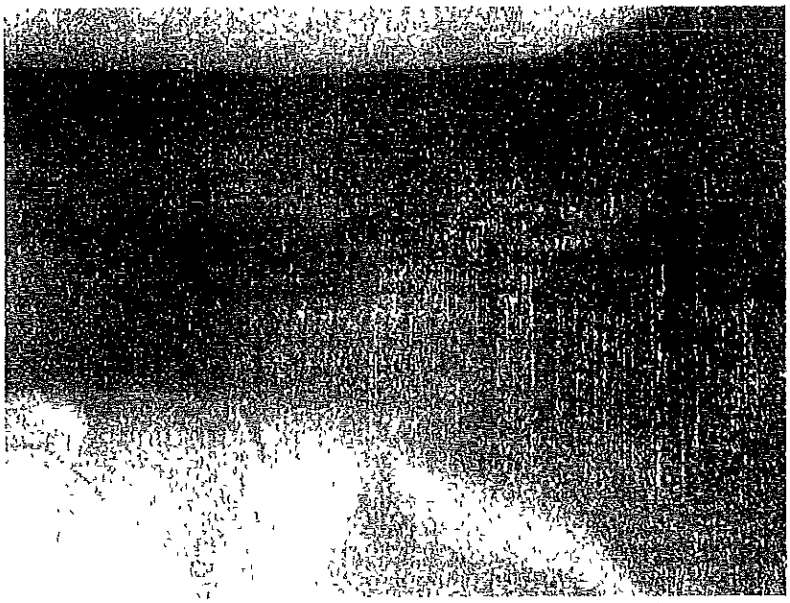












11. DIAGNOSIS AND OPINION

11.1 Since the index accident, Mr Furlong has had a significant amount of chronic musculoskeletal pain, neuropathic pain and disability.

11.2 Diagnostically, Mr Furlong has evidence of the following long term pain problem:

11.2.1 Chronic Musculoskeletal Pain:

There is evidence of chronic musculoskeletal pain including the following:

- Left ankle pain.

11.2.2 Neuropathic Pain:

Mr Furlong has evidence of neuropathic pain. This is pain which occurs when there is damage and/or dysfunction to an element of the nervous system which results in hypersensitivity of the nervous system. Diagnostically, he has evidence of the following type of neuropathic pain:

- Left lower limb neuropathic pain

11.3 What is pain?

11.3.1 The International Association for the Study of Pain (IASP) is the leading professional forum for science, practice, and education in the field of pain. Pain is defined as an unpleasant sensory and emotional experience, which we primarily associate with tissue damage or described in terms of tissue damage or both, according to the IASP. Their definition (1979) describes pain as a sensory and emotional experience, and does not require any identifiable tissue damage to verify the complaint of pain. A more useful definition is to say that pain is whatever the patient says it is.

11.3.2 Pain comes in 2 time courses; acute pain and chronic pain. By definition, acute pain lasts for less than 3 months and includes post operative pain, pain following road traffic accidents and, most acutely, painful medical and surgical conditions such as appendicitis, peritonitis and other acute inflammatory conditions. Chronic pain by definition is pain that lasts for 3 months or more and includes common complaints such as neck pain, lower back pain, joint pain etc.

11.3.3 The National Institute for Health and Care Excellence (NICE), 2008, acknowledges chronic pain as pain that persists for more than three months, or beyond the normal course of a disease or expected time of healing. According to NICE, this pain then becomes a significant medical condition in itself rather than being a symptom. Chronic pain is accompanied by physiological and psychological changes such as sleep disturbances, irritability, medication dependence and frequent absence from work. Emotional withdrawal and depression are also common, which can strain family and social interactions.

11.3.4 There is a large amount of literature on short, medium and long term peripheral and central nervous system changes resulting from pain, and which lead to hypersensitivity to pain at the periphery; to pain response to previously nonnoxious stimuli such as touch and temperature; to spontaneous firing; to changes in modulation and transmission, and actual neurological changes.

11.4 Types of Pain

11.4.1 Pain can be divided into 2 major types; nociceptive or normal pain is where the pain signalling pathways are all intact, and this is most commonly found with musculoskeletal pain, e.g. lower back pain and neck pain. Nociceptive or somatic pain is logical – a doctor can easily identify and understand the patient's pain. Nociceptive pain includes:

- Whiplash injury
- Lower back pain
- Shoulder pain

- Joint pain

11.4.2 Neuropathic pain on the other hand, is a form of pain where there is damage and/or dysfunction to an element of the nervous system. Such injuries can give rise to paraesthesia, numbness, tingling, or abnormal sensations. Neuropathic pain includes:

- Diabetic neuropathy
- Post herpetic neuralgia
- Post traumatic neuropathic pain
- Complex regional pain syndrome (CRPS)
- Post-surgical neuropathic pain.

11.4.3 Patients usually describe very florid symptoms with this. They will describe their pain as sharp, stabbing, like electric shocks, like hot stabbing pokers or razor blades. They also suffer with a lot of burning pain. In addition to the pain, patients will experience sensory dysfunction and light touch and pinprick sensations will be felt as exaggerated. This can often lead to problems, for instance in showering and wearing clothing where the affected area can be acutely painful.

11.4.4 Along with pain, patients often have associated disability. For instance, where a limb movement of the affected area causes pain they will start to disuse the area leading to neglect, muscle wasting and, in extreme cases, fibrosis and contractures. This leads to further disability.

11.5 Pain Physiology

11.5.1 The pain-signalling pathway is an immensely complex neurophysiological system. Teleologically, pain has been developed in organisms to keep the organism out of harm's way. For instance, if a limb is injured there is an initial reflex action to remove the limb from danger. If it is injured,

the pain will signal to the organism not to use that area until it has healed.

11.5.2 In essence, there are pain receptors that are receptive to motor, thermal and chemical stimuli found throughout the body, bother peripherally and in the viscera. These are connected by mostly A delta and C fibres back to the spinal cord. In the spinal cord pain transmission can be modulated, either amplified or depressed, by a number of local ascending and descending inhibitory and excitatory neural circuits.

11.5.3 After this modulation the pain signal is transmitted up through the spinal cord via 5 different tracks, the most common of which is the spinothalamic tract. These pain fibres then end up in about 5 different areas of the brain as there is no central pain processing area and these discrete areas in the brain translate in different aspects of pain including intensity, type, character, emotional response and other valuable information.

11.6 Prevalence of Chronic Pain

11.6.1 It has been estimated that one in seven of the UK population lives with chronic pain, i.e. pain of more than 3 months duration. This equates to approximately 7-14% of the UK population and these findings are similar elsewhere in the western world.

11.7 'Good days' and 'bad days'

11.7.1 Typically, chronic pain (as opposed to acute pain) fluctuates in severity. It is a well-recognized phenomenon in Pain Clinics that patients will often describe 'good' days and 'bad' days. Bad days would be those when they experience significant flare-ups in their pain. This phenomenon is not only common but is also generally accepted as the way in which chronic pain manifests.

11.7.2 In addition, when considering pain, it is important to remember that a significant proportion of chronic pain patients are anxious about attending medical appointments, especially when there are legal or financial implications associated with their diagnosis or treatment. For the avoidance of doubt, by this I do not mean necessarily medicolegal appointments, but any medical appointment where there are other related matters, such as appointments affecting employment, benefits, disability status and the financial implications of these.

11.7.3 It is also common for patients in chronic pain to find that travel is painful or exacerbates their pain. As a result, travelling to medical appointments is not only difficult for such patients, but painful, exacerbating their overall pain experience. This may well (and often does) mean that the patient will focus on their pain, and when examined or questioned about their pain, respond according to a 'bad day' experience rather than a normal day. This is one reason why the self-reporting of pain in sections 6, 7 and 9 above is requested prior to their examination, to be completed in their own time and in the comfort of their own home. This should avoid false exacerbation of their reported pain due to anxiety, stress and exacerbation due to travel.

11.8 The Biopsychosocial Model of pain

11.8.1 Nowadays, pain medicine practitioners tend to use a biopsychosocial model of pain. The biopsychosocial model of illness was first presented in 1977 by George Engel. At the time, his concept was innovative, and described a dynamic interaction between psychological, social and pathophysiological variables. It highlighted the hypothesis that the workings of the mind could affect the body, as much as the workings of the body could affect the mind. Such a model has since been widely recognised and accepted in explaining chronic pain syndromes, and has led to an important shift in the way that pain is researched, diagnosed and treated. There is now a substantial body of supporting studies for this model.

11.8.2 A biomedical perspective focuses on cause and physiological explanations for chronic pain. A psychogenic view, on the other hand, suggests pain as physical manifestations of psychological difficulties. Psychological factors have been reported to be predictive of long-term disability for many pain syndromes as well as for pain severity, emotional distress, and treatment seeking.

11.8.3 Both of these models are one dimensional and inaccurate, however. Only a biopsychosocial view provides a complete and holistic model. It views illness as a dynamic and reciprocal interaction between biological, psychological, and sociocultural factors that shape the person's response to pain. It presumes some form of physical pathology or at least physical changes in the muscles, joints, or nerves that generate nociceptive input to the brain. (Turk & Okifuji, 2002).

11.9 Depression

Depression does make a patient potentially more vulnerable to the development of a pain condition. However, not all patients suffering from depression develop chronic pain conditions and not all patients with chronic pain suffer from depression. Whether or not there is a link between pain and depression is a controversial topic, but any link is highly unlikely to be simple cause and effect.

12. CAUSATION

12.1 Summary of Pre-Index Accident/Incident Medical Records

12.1.1 Prior to the index accident, Mr Furlong had 2 documented episodes of depression in March 2002 and December 2007. Of note he had no ongoing investigations or treatment for pain in his lower limbs. This is fully outlined in Section 4 "Pre-Accident/Incident Medical Records".

12.2 Summary of Index Accident

12.2.1 Mr Furlong was involved in the index accident on 1 November 2011 whilst walking along a poorly lit public footpath, his left foot became caught in a pothole and he sustained a fracture to his left tibia, requiring surgical intervention.

12.3 Summary of Post Index-Accident/Incident Medical Records

12.3.1 Following the index accident, Mr Furlong suffered an intra-articular fracture of the distal tibia and distal shaft of the fibular, with marked comminution and displacement of the fracture fragments.

12.3.2 Mr Furlong was treated with surgical intervention including an ORIF (open reduction and internal fixation) of the distal tibia/fibular fractures, and was placed in a light weight cast. Mr Furlong was kept under review by the Department of Orthopaedic Surgery and his GP.

12.3.3 Mr Furlong received the following treatment post index-accident

- Analgesic medication
- Physiotherapy based rehabilitation
- Surgical intervention

12.3.4 Whilst Mr Furlong does fulfil the criteria for a diagnosis of chronic musculoskeletal pain and neuropathic pain affecting his left ankle and leg, he does not fulfil the strict diagnostic criteria for a diagnosis of Complex Regional Pain Syndrome (CRPS). This can be found at Appendix D.

12.4 Direct Causation:

12.4.1 On the balance of probabilities, the following pain has been caused as a direct result of the index accident:

Chronic Musculoskeletal Pain:

- Left ankle pain

Neuropathic Pain:

- Left lower limb neuropathic pain

13. SPECIFIC INSTRUCTIONS AND QUESTIONS POSED

I have been asked to respond to the following instruction and comment specifically on the following points in this report:

It has been identified that the Claimant has developed Complex Regional Pain Syndrome as a result of the accident.

13.1 We would be obliged if you would examine the Claimant and let us have a full and detailed report dealing with any relevant pre-accident medical history, the injuries sustained, treatment received and present condition, dealing in particular with the capacity for work and giving a prognosis.

This is dealt with in the bulk of this Medicolegal Report.

13.2 It is central to our assessment of the extent of the Claimants injuries to establish the extent and duration of any continuing disability. Accordingly, in the prognosis section we would ask you to specifically comment on any areas of continuing complaint or disability or impact on daily living. If there is such continuing disability you should comment upon the level of suffering or inconvenience caused and, if you are able, give your view as to when or if the complaint or disability is likely to resolve. If you recommend any further investigations or treatment, please provide us with costings in respect of these.

Please see the following Sections:

- Section 9 – "Employment & Activities of Daily Living"
- Section 14 – "Prognosis & Recommendations"

- Section 15 – "Treatment & Outcomes using a multi-model/multi-disciplinary approach to pain management"

14. PROGNOSIS & RECOMMENDATIONS

14.1 Of note, treatment for pain is a continuum, starting with the most conservative treatment, i.e. analgesic medication combined with physiotherapy-based rehabilitation. Unfortunately, it is not possible to predict how an individual patient will respond to treatment, and if they fail with the conservative treatment options then it becomes necessary to move on to progressively more invasive treatment.

14.2 Since the index accident on 1 November 2011, Mr Furlong has had a significant amount of chronic musculoskeletal pain, neuropathic pain and disability. On the balance of probabilities, without continuing adequate treatment, it is unlikely there will be a spontaneous improvement in Mr Furlong's symptoms. In terms of treatment, however, there are a number of options that they could be helped with.

14.3 Pharmacological Treatments:
For pain treatment we consult the Abridged Analgesic Ladder:

- Step 1 for mild pain includes Paracetamol, non-steroidals and COX-2 inhibitors.
- Step 2 is Step 1 plus the addition of weak opioids including Codeine, Dihydrocodeine and Tramadol.
- Step 3 includes Step 1 and the addition of strong opioids including Morphine, Oxycodone and Buprenorphine etc.

In the past few years there has been an increasing use of opiates, that is Morphine-like drugs, in the treatment of chronic non-malignant pain. This has in some way been down to some of the more deleterious and irreversible adverse effects of the anti-inflammatory medications, which in long term use have been associated with renal impairment and an increase in strokes and heart attacks.

14.3.1 Specific Medication for Neuropathic (Nerve) Pain:

These medications are drugs that are generally used for other purposes but that have been found to be useful in neuropathic pain. Examples include:

- Antidepressants, e.g. Amitriptyline.
- Anticonvulsants, e.g. Gabapentin, Pregabalin, Carbamazepine, Valproate.
- Opioid Medication, e.g. Morphine, Oxycodone, Buprenorphine.
- Local Anaesthetics, e.g. Lignocaine patches.
- Other Agents, including NMDA antagonists, Sympatholytics, GABAergics and Capsaicin.

The pharmaceutical industry has a significant interest in medications for neuropathic pain, as it is seen as a significant market, and other medications are under development. Agents include Ziconotide, preparation from sea snail toxin, Epibatidine preparation from the Ecuadorian poison dart frog and other preparations in the pipeline.

14.3.2 Recommendations for Medication for

Mr Furlong is currently on medication including an analgesic regime, as outlined in section 6.8 Medications for Pain. This includes the following:

1	Paracetamol	Non-opioid analgesic medication
2	Codeine	Weak opioid analgesic medication
3	Diclofenac	Non-steroidal anti-inflammatory drug

I would recommend that Mr Furlong is treated with multimodal analgesia; that is using different analgesic agents with different mechanisms of action to overall produce a therapeutic result. He has a mixture of chronic musculoskeletal and neuropathic pain and therefore would require medication to address both of these problems. I would recommend the following:

- Anti-Inflammatory Medication, e.g. Celecoxib or Diclofenac: I would recommend a short, high dose course of a strong anti-inflammatory medication to reduce the chronic inflammatory component of his pain.

- Antineuropathic Medication, e.g. Pregabalin or Amitriptyline: I would recommend a slowly escalating dose of an appropriate antineuropathic medication to try and reduce the neuropathic elements of the pain. It may be necessary to use a combination of more than one antineuropathic medication in order to provide optimum pain relief.

- Weak Opioid Analgesic Medication, e.g. Tramadol or Tapentadol: I would recommend this on an as required basis to reduce any flare ups of pain.

- Strong Opioid Analgesic Medication, e.g. Oxycodone: I would recommend this on an as required basis for any severe break through pain that he may experience.

- Paracetamol: I would recommend 1 g PO p.r.n. to a maximum of 4 times per day.

14.4 Physiotherapy Based Rehabilitation:

The aim of either the medication or the minimally invasive pain management procedures is to break the cycle of pain to give patients a pain free window for as long as possible in order for them to participate in gentle, graded physiotherapy based rehabilitation. This would look at gradually increasing the range of movement, increasing strength and flexibility and building up confidence to participate in activities. The physiotherapy would include a number of different treatment modalities including:

- Joint mobilisation.
- Manual treatment interventions.
- Stretching exercises.
- Strengthening exercises.

- Stabilisation exercises.
- Home exercise programme.
- Relevant advice and education.
- Hydrotherapy treatment, if indicated.
- Graded Desensitisation Programme

14.5 Minimally Invasive Pain Management Techniques:

There are a number of different procedures that are used either with or without x ray guidance. Minimally invasive pain management procedures for musculoskeletal pain include:

- Epidurals.
- Facet joint injections.
- Nerve root injections.
- Local nerve blocks.
- Intra-articular injections.

Minimally invasive pain management procedures for neuropathic pain include:

- Intravenous Guanethidine blocks (IVG).
- Lumbar sympathectomy.
- Stellate ganglion nerve blocks.
- Ganglion of Impar.
- Occipital nerve blocks.

Most of these procedures are performed under x ray guidance and can usually be done either with the patient awake under local anaesthesia or the addition of a small amount of sedation. Most of the procedures involved the injection of mixtures of local anaesthetic and long acting steroid preparations.

Another technique, which has been around since the 1950's is the use of radiofrequency technology. This can be used as a destructive mode (radiofrequency denervation), for example in lumbar facet joint pain to destroy the local pain mediating nerve, or can be used in a non-destructive mode (pulsed radiofrequency) for areas of neuropathic pain. In the destructive mode nerves are actually destroyed with the application of an electric field at high

temperature. In a non-destructive mode pulses of an electrical field are passed through the local nerves and there is excellent basic science evidence of the beneficial effects of pulsed electrical fields on nerve membranes including stabilising them, reducing their activation threshold and reducing the amount of spontaneous activity in them.

Of note, in terms of minimally invasive pain management procedures, in general there is approximately a 65% chance of success giving a reduction in pain of approximately 30-40% for at least 6 months. In the intervening time where there is either a pain free window or a reduction in pain, the rehabilitation therapy should take place.

14.5.1 Recommendations for Minimally Invasive Pain Management Techniques for

The mainstay of treatment is conservative with medication and physiotherapy-based rehabilitation. However, if Mr Furlong failed to respond to medication, either due to a lack of efficacy or due to adverse effects, there are some simple minimally invasive pain management procedures that can be offered. I would recommend the following:

- X-ray guided pulsed radiofrequency to the L5 and S1 nerve roots.

14.6 Psychologically Based Therapy:

It is often necessary to use psychologically based therapies including cognitive behavioural therapy, conditioning, psychoanalysis, relaxation and biofeedback. Only very rarely is it necessary to involve psychiatric input, in particular where clients have suicidal ideation or there is an underlying significant psychiatric problem such as severe depression or schizophrenia.

14.6.1 Recommendations for Psychologically Based Therapy for

There is no doubt that Mr Furlong has increased levels of anxiety and depression. I would recommend the help of a clinical pain psychologist to look at self help techniques for them to manage their own pain, which

will give him greater mastery over their symptoms. These include teaching visualisation techniques, relaxation techniques, goal setting and pacing, which are extremely valuable in patients with pain problems. This would run concurrently with any pain treatment and physiotherapy.

14.7 Advanced Pain Management Procedures:

These techniques are not specifically indicated in this case.

14.8 Occupational Therapy:

I would envisage that if it is possible to break the cycle of pain and improve Mr Furlong symptoms, it will be possible to start to physically and psychologically rehabilitate them. Once we get to this position, it would be possible to get an assessment for them with an occupational therapy physician with a view to planning a graded return to the workplace, possibly on a part time basis in the first instance. However, this would all be dependent on improving their immediate pain and disability symptoms.

14.9 Surgical Intervention:

I note Mr Furlong still has some metalwork in situ. I would recommend the opinion of a Consultant Orthopaedic Foot and Ankle Surgeon in regard to whether removal of the metalwork may be helpful in alleviating some of Mr Furlong's pain. In some circumstances following surgical removal of metalwork, neuropathic pain symptoms can be improved. However, this would depend on specialist opinion and would of course need to take into consideration the specific location of the metalwork.

14.10 Pain Management Program:

14.10.1 There has been a major shift towards active treatment and management of chronic pain in recent years aimed at maximising ability, managing pain symptoms and minimising any residual disability.

14.10.2 Pain management programmes seek to teach patients, usually in groups on an inpatient or outpatient basis, a variety of self help

techniques to help them manage their pain more efficiently. These sessions are done with a multidisciplinary team, usually comprising of a doctor, specialist pain nurse, physiotherapist, occupational therapist, pharmacist and other staff. Techniques taught include management of medication, coping strategies and contingency plans, pacing of activity, education of patients regarding their pain, teaching patients goal setting and trying to break certain negative pain behaviours.

14.10.3 Overall, I would recommend that Mr Furlong would be best treated using multi-disciplinary treatment including medication, physiotherapy based rehabilitation and psychologically based therapy as outlined above. Mr Furlong may well be best served and receive all of these treatments in a combined manner on a suitable, pain management program.

14.10.4 There are a number of Pain Management programmes (PMPs) available across the UK including:

- INPUT - St Thomas's Hospital, London
- Pain Management Programme - Salisbury District Hospital
- Pain Management Programme - Walton Hospital, Liverpool
- Pain Management Programme - Astley Ainslie Hospital, Edinburgh
- Pain Management Programme - Wythenshawe Hospital, Manchester
- Pain Management Programme - Royal National Hospital for Rheumatic Diseases, Bath
- Pain Education Programme (PEP) - Royal Hallamshire Hospital, Sheffield

14.10.5 The gateway for referral to a Pain Management Programme is normally through the client's general practitioner via the pain clinic at the local hospital. However, as costs are considerable for such treatment, the initial referral may never be considered by the general practitioner. However, many Pain Management Programmes will take private patients and extra contractual referrals (ECRs), ie a referral from

outside the immediate catchment area of each Pain Management Programme.

14.10.6 Pain Management Programmes vary: some are 2 – 4 week residential programmes while others are based in hospital outpatient departments, or community settings, and continue for several weeks. Programmes are run by pain specialists including psychologists, physiotherapists, nurses, doctors and sometimes occupational therapists and pharmacists.

15. TREATMENT OUTCOMES USING A MULTIMODAL, MULTIDISCIPLINARY APPROACH TO PAIN MANAGEMENT

15.1 There are a number of different treatment options available for Mr Furlong as outlined in the prognosis section.

15.2 As stated above, treatment is a continuum, starting with the most conservative treatment, i.e. analgesic medication combined with physiotherapy based rehabilitation. Unfortunately, it is not possible to predict how an individual patient will respond to treatment and if they fail with the conservative treatment options then it becomes necessary to move on to progressively more invasive treatment.

15.3 The main aim of treatment is to obtain a pain free window using medication and/or minimally invasive pain management techniques, which would allow them to fully participate in their physiotherapy based rehabilitation.

15.4 I would recommend a full treatment cycle of at least 5 months, during which Mr Furlong should undergo multimodal, multidisciplinary treatment, as outlined above.

15.5 The combined multidisciplinary assessment (including physiotherapy/ psychology/ occupational therapy) would give the best assessment of his rehabilitation requirements.

15.6 Physiotherapy based rehabilitation would include one to one sessions with a specialist physiotherapist in addition to a daily home exercise programme.

15.7 Once Mr Furlong has undergone the full multimodal, multidisciplinary treatment cycle, Mr Furlong can be re-assessed to review the outcome of treatment, including any reductions in pain and disability. Therefore, it should be stressed that this report can only offer a prognosis at the time of examination. After treatment has been commenced and is completed, a further evaluation would need to be made to assess the outcome of the treatment, and at that time my opinion and prognosis may need to be revised.

16. DECLARATION AND SIGNATURE

I understand my overriding duty is to the court, both in preparing reports and giving oral evidence. I have complied with and will continue to comply with that duty.

I am aware of the requirements of Part 35 and practice direction 35, the protocol for instructing experts to give evidence in civil claims and the practice direction on pre-action conduct

I have set out in my report what I understand from those instructing me to be the questions in respect of which my opinion as an expert is required.

I have done my best, in preparing this report, to be accurate and complete. I have mentioned all matters that I regard as relevant to the opinions I have expressed All of the matters on which I have expressed an opinion lie within my field of expertise.

I have drawn attention to all matters, of which I am aware, that might adversely affect my opinion.

Wherever I have no personal knowledge, I have indicated the source of factual information.

I have not included or excluded anything which has been suggested to me by anyone, including those instructing me, without forming my own independent view of the matter.

I will notify those instructing me if, for any reason, I subsequently consider that the report requires any correction or qualification.

I understand that this report will be the evidence that I will give under oath, subject to any correction or qualification I may make before swearing to its veracity and I may be cross-examined on my report by a cross examiner assisted by an expert.

I have not entered into any agreement where the amount of payment of my fee is in any way dependant on the outcome of the case.

Statement of Truth:
I confirm I have made clear which facts and matters referred to in this report are within my own knowledge and which are not. Those that are within my knowledge I confirm to be true. The opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.

DR C A JENNER MB BS, FRCA FFPMRCA
Consultant in Pain Medicine & Anaesthesia
London Pain Clinic
Dated this 7th day of October, 2014

17. APPENDIX A - IASP (International Association for the Study of Pain) Pain Terminology (Abridged)[2]

The International Association of Pain's (IASP) definition of pain is one which is widely accepted within chronic pain practise, and one which most pain experts and clinicians would agree with and use. However, the IASP definition of pain is not a diagnosis, although it may prove part of a number of factors that contribute to a diagnosis of chronic pain.

NOTE:
The following pain terminology is from "Part III: Pain Terms, A Current List with Definitions and Notes on Usage" (pp 209-214) Classification of Chronic Pain, Second Edition, IASP Task Force on Taxonomy, edited by H. Merskey and N. Bogduk, IASP Press, Seattle, © 1994.

Pain Terms

Allodynia - Pain due to a stimulus which does not normally provoke pain.

Analgesia - Absence of pain in response to stimulation which would normally be painful.

Anaesthesia Dolorosa - Pain in an area or region which is anaesthetic.

Causalgia - A syndrome of sustained burning pain, allodynia, and hyperpathia after a traumatic nerve lesion, often combined with vasomotor and sudomotor dysfunction and later trophic changes.

Central Pain - Pain initiated or caused by a primary lesion or dysfunction in the central nervous system.

[2] The pain terminology was modified and approved for publication by the IASP Council in Kyoto, November 29-30, 2007

Dysesthesia - An unpleasant abnormal sensation, whether spontaneous or evoked.

Hyperalgesia - An increased response to a stimulus which is normally painful.

Hyperesthesia - Increased sensitivity to stimulation, excluding the special senses.

Hyperpathia - A painful syndrome characterized by an abnormally painful reaction to a stimulus, especially a repetitive stimulus, as well as an increased threshold.

Hypoalgesia - Diminished pain in response to a normally painful stimulus.

Hypoesthesia - Decreased sensitivity to stimulation, excluding the special senses.

Neuralgia - Pain in the distribution of a nerve or nerves.

Neuritis - Inflammation of a nerve or nerves.

Neurogenic Pain - Pain initiated or caused by a primary lesion, dysfunction, or transitory perturbation in the peripheral or central nervous system.

Neuropathic Pain - Pain initiated or caused by a primary lesion or dysfunction in the nervous system.

Neuropathy - A disturbance of function or pathological change in a nerve: in one nerve, mononeuropathy; in several nerves, mononeuropathy multiplex; if diffuse and bilateral, polyneuropathy.

Nociceptor - A receptor preferentially sensitive to a noxious stimulus or to a stimulus which would become noxious if prolonged.

Noxious Stimulus - A noxious stimulus is one which is damaging to normal tissues.

Pain - An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

Pain Threshold - The least experience of pain which a subject can recognize.

Pain Tolerance Level - The greatest level of pain which a subject is prepared to tolerate.

Paraesthesia - An abnormal sensation, whether spontaneous or evoked.

Peripheral Neurogenic Pain - Pain initiated or caused by a primary lesion or dysfunction or transitory perturbation in the peripheral nervous system.

Peripheral Neuropathic Pain - Pain initiated or caused by a primary lesion or dysfunction in the peripheral nervous system.

18. APPENDIX B – LIST OF RELEVANT AND/OR SUPPORTING REFERENCES/ LITERATURE AVAILABE ON REQUEST

I can provide on request a copy of the following academic papers which may be relevant to this case or provide useful background information.

Chronic Pain

1. Psychological Factors in Chronic Pain: Evolution and Revolution (Turk & Okifuji, 2002, From Journal of Consulting and Clinical Psychology, 2002, Vol 70, No 3, pp 678-690)

2. Chronic pain may change the structure of the brain (May, 2008, PAIN 137 (2008) pp 7-15)

3. How Neuroimaging Studies Have Challenged Us to rethink: Is Chronic Pain a Disease? (Tracey & Bushnell, 2009, from The Journal of pain, Vol 10, No 11 (November) 2009, pp 1113-1120)

Neuropathic Pain

4. Translation of symptoms and signs into mechanisms in neuropathic pain (Jensen & Baron, 2003 from PAIN 102 (2003) pages 1-8)

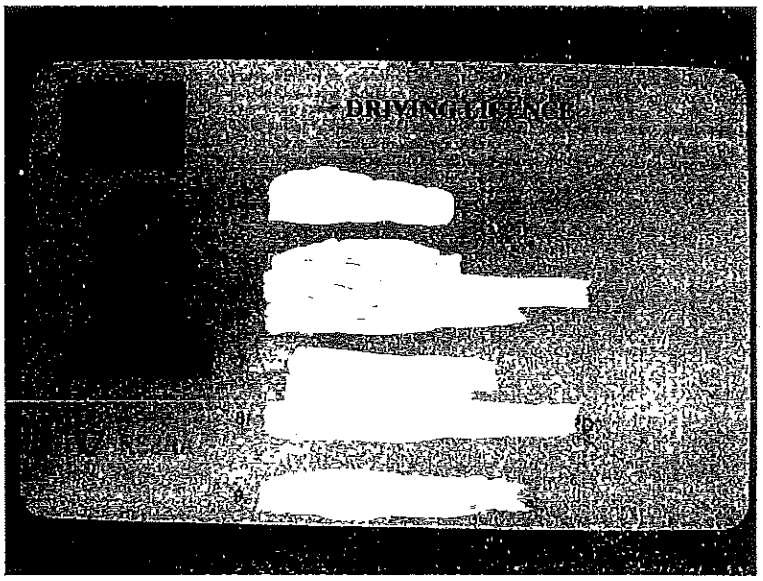
5. Neuropathic Pain: A Maladaptive Response of the Nervous system to damage (Costigan, Scholz & Woolf from Annu Rev Neurosci 2009; 32: pp 1-32

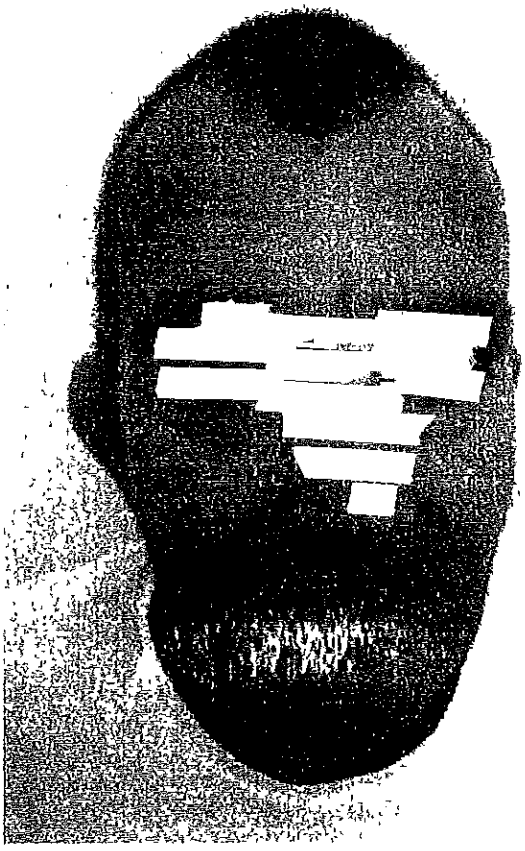
CRPS

6. Clinical features and pathophysiology of complex regional pain syndrome (Marinus et al, Lancet Neurol 2011, pp 637-648)

7. Validation of proposed diagnostic criteria (the "Budapest Criteria") for Complex regional Pain Syndrome (Harden et al, 2010 from PAIN 150 (2010) pp 268-274)

19. APPENDIX C – PHOTOGRAPHS OF IDENTIFICATION USED TO ESTABLISH IDENTITY OF EXAMINEE





20. APPENDIX D – COMPLEX REGIONAL PAIN SYNDROME CRITERIA (CRPS)

20.1 The International Association for the Study of Pain (IASP) lists the diagnostic criteria for Complex Regional Pain Syndrome Type 1 (CRPS1) as follows:

1. The presence of an initiating noxious event or a cause of immobilisation.
2. Continuing pain; allodynia (perception of pain from a non-painful stimulus) or hyperalgesia disproportionate to the inciting event.
3. Evidence at some time of oedema, changes in skin blood flow or abnormal sudomotor activity in the area of pain.
4. The diagnosis is excluded by the existence of any condition that would otherwise count for the degree of pain and dysfunction.

20.2 The International Consensus Group Budapest (2005) - Revised Clinical Diagnostic Criteria for CRPS:

a. Continuing pain that is disproportionate to any inciting event.

b. Patient must report at least one symptom in 3 of the 4 categories:

- Sensory: Reports of hyperaesthesia and/or allodynia.
- Vasomotor: Reports of temperature asymmetry and/or skin colour changes and/or skin colour asymmetry.
- Sudomotor/oedema: Reports of oedema and/or sweating changes and/or sweating asymmetry.
- Motor/trophic: Reports of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic change (hair, nail, skin).

c. Must display at least one sign at time of evaluation in 2 or more of the 4 categories:

- **Sensory:** Evidence of hyperaesthesia (to pin prick) and/or allodynia (to light touch and/or deep somatic pressure and/or joint movement.
- **Vasomotor:** Evidence of temperature asymmetry and/or skin colour changes and/or skin colour asymmetry.
- **Sudomotor/oedema:** Evidence of oedema and/or sweating changes and/or sweating asymmetry.
- **Motor/trophic:** Evidence of decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic change (hair, nail, skin).

d. There is no other diagnosis that better explains the signs and symptoms.

20.3 I can on request supply a copy of the following documents:

- Chapter 27. Complex Regional Pain Syndromes by Peter R Wilson taken from the Clinical Pain Management Textbook 2nd Edition: Chronic Pain. Lead Editor Professor Andrew S C Rice.

- Updated Interdisciplinary Clinical Pathway for CRPS – Report of an Expert Panel. Stanton Hicks MD 2002.

STATEMENT OF WITNESS

(C J ACT 1967, s.9, M C. ACT 1980, Ss5A (3)(a) and 5(B); CPR 2010, r27.2)

STATEMENT OF Gareth

Age of Witness (if over 18, enter "over 18")

Occupation of Witness

.... **UNEMPLOYED**..... ....

The following statement, consisting of 7 page(s) each signed by me, is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated 27-7-2015 Signed X J. S.....

I have been asked by investigators at Beach Borough Council to provide this statement in connection with an incident at Seapoint Railway Station going back to 2011. This was in November 2011 I believe around the 1st and it was in the evening. It was a dark evening not an unpleasant one just very dark and not wet.

On this day both myself and Chris Furlong had visited my brother Dave who lives in Beach. We boarded the train but neither of us had tickets for the journey. I had sufficient cash to cover the journey but I can offer no reasonable explanation as to why I had no ticket.

I originally thought I got off at Hull TS but I now recall this as Seapoint I say this as firstly investigator queried this at interview and secondly we visited that station later on in person and I can say without doubt we are talking about Seapoint Train stations are not of interest to me although I do travel on them fairly frequently.

As we got to the train station Chris Furlong wanted to bunk the train. I was unsure if the main barrier was manned or not. I am aware that at some times the staff have gone home and the stations are unmanned so they leave the barriers open. I do not believe that Chris had the money to pay for a ticket but I did have some. I had enough to pay for a ticket and indeed a taxi from that station but

Chris to the best of my recollection did not have any. I am unable to say if the barrier at Seapoint station barrier was open or not or indeed manned.

The train from Seach arrives at Platform Number 2 which is the opposite platform to the sea wall. Somehow we both ended up on the opposite Platform how we got there I do not know although I would say this was just the passage of time recalling this. I originally thought the train came onto this platform but following my visit to the station with investigator we must have arrived and travelled over the bridge. By now we were both on the platform nearest to the sea. We walked along to where the wall is shortest just past the gent's toilets. This wall starts high probably above my head then after a short while slopes down very quickly. It would now be possible to see over it and out to the sea. However due to it being dark vision was very limited. Chris then got his tobacco tin and held it out with his arm fully stretched out. His hand was beyond the walls edge. He dropped the tin I assume to try and gauge the drop on the far side of the wall. I guessed that Chris may have thought it was not too much of a distance from the wall to the pavement the other side of the wall. Chris then climbed over the wall and was now dangling on the sea side of the wall hanging onto the top with his hands. I recall seeing his fingers on the brick then they slid off. When he totally disappeared over I peered over but could not see anything due to the poor light. I heard Chris say "don't jump". I did not hear anything no bang no snap nothing just Chris say what he did. I then ran to the end of the brick wall to try and get over the wall to assist Chris . At the end of the wall there is a metal fence. This fence is a little lower than the wall though not a great deal lower. Also the metal fence goes on a step which you can stand on. So if you jump off the step onto the path it's much easier and much lower than jumping from where Chris came over the wall. When I went to the station later

Signed X. J. S. .....

with investigator you can see this section past the thick blue line I would say off the platform.

In my tape recorded notes to investigator I estimated that the distance between where Chris Firlong leapt over the wall and the metal fence was about 10 – 15 feet away. Having visited this with investigator and done a walk through I now know that the distance I ran along the station to the metal fence and to where Chris was laying on the floor was substantially more than what I said. I assume that this was just the passage of time and the weather nothing else.

I then ran along the path to where Chris was lying. He was in something of a heap and clearly in some sort of distress. I could tell something was wrong I could tell this as his voice had changed. He was clearly in pain and in some difficulty. I picked Chris up as it seemed the most obvious thing to do. He had one of his arm over my shoulder and I had my left arm around his waist area and we started walking along the footpath now with the sea to my right. Neither of us tripped on the footpath in the dark although I could tell from underfoot it was a little uneven. I cannot recall what the lighting conditions where at this point although it was quite dark. When I visited the station later with investigator I can say that we walked like this from where Chris I went over the wall until about 2 - 3 drain pipes down. This is perhaps about 100 - 150 feet. I pointed to investigator where we started this from picking Chris up and to where we stopped. At the point where we stopped I believe it was at the drain pipe I previously mentioned which is half embedded into the wall. There is also some sort of orange circle now painted on the footpath next to the embedded waste pipe. I would estimate I carried Chris on my shoulder to this point. I believe that I had now called an ambulance which had arrived to meet us quite quickly just along the footpath. At this point I put

Signed .....

down he was clearly in difficulty and could not walk any further. As he was over my shoulder he said "I can't go no more". I didn't really see anything I just picked him up off the floor he said "I think I've done something to my ankle I think I've broke it or whatever". I did consider calling perhaps taxi to get us home but the situation was beyond that Chris needed medical attention as he was starting to shiver. I called the ambulance and left Chris sitting where he stopped as I thought that the ambulance may have difficulty finding us so I went to meet them.

I do not recall any other person present on the footpath just myself and Chris Furlong. There may have been but in the time I was dealing with Chris and on the wrong side of the wall I did not see anyone. I did not see any station staff at all.

Regarding the footpath. I know it is a bit uneven in places but you can walk along it with little difficulty. In this case the footpath was not responsible for injuring Chris He, in my opinion, injured his ankle when he climbed over the wall and dropped off. It could have been avoided by walking through the barrier. We have both walked along this path before and never fallen over. Certainly in my case but I am not aware of Chris falling over not even when it is light. I repeat to the very best of my knowledge I am not aware of Chris falling or tripping on the footpath at the rear of Seapoint Station.

Chris was taken to hospital by ambulance and dealt with at the hospital which at this point told me the diagnosis was a broken ankle. I can say without doubt that up until Chris went over the wall he did not appear to me to have anything wrong with him and walked throughout the day quite normally. I can say that I did not notice anything wrong on the train and along the station platform. The only time I became aware of an issue was when I went to Chris 's aid on the far side of the wall

Signed .....

CONTINUATION OF STATEMENT OF

I went back to the 88 North Road address until Chris was discharged from Hospital. The 88 North Road address is where Chris was living at the time. This was a good few minutes' walk from the station which we both had done on numerous occasions. This was our reason for being on the station that evening.

After a good couple of months I was told by Chris that he had put in a claim for compensation for breaking his ankle. I was a little shocked and asked him "What for". I did not approve of this and I knew it was wrong what he was doing.

told me that he was going to tell the solicitors or the council he had tripped down the hole or whatever. I am positive that's what he said no doubt. I say again he did not fall down a hole or trip. His injuries were caused, in my opinion, from what I witnessed which was Chris climbing over the wall and dropping off. I say again he was walking about that day when I was with him perfectly well. We had no reason to be on that footpath none at all that evening on a dark winters night. We were returning from Dave . house in Beach, both decided to not pay our tickets. The remainder is how I have described it from what I saw from being present with Chris that day. Chris , I have absolutely no doubt about it, gained his injury dropping off the wall. Had he not taken this cause of action he would never broke his ankle and suffered the injuries he did.

I cannot recall when but I later received some correspondence from a firm. It may have been a firm of solicitors or may have been claims handlers I cannot recall. The only bit I do recall was that they were requesting I be a witness. I refused. At the time I was with my ex-partner. I told her I do not approve of it anyway. I ripped the papers up and threw them away in the bin. That was the last thing I saw of them. Although I have spoken to Chris since the incident I do not recall speaking to him

Signed D. S. .....

about the claim. It would be illogical to suggest I haven't spoken with him as for periods of time we lived together and for a short time at the same house. I cannot however recall speaking to him about the accident. He knows that I do not approve of the false claim and knows my opinion on that mater. I told him of my concern when the papers came through. He said "why why are you not gonna help me you're the only person what was there?" I said like "cos I don't believe in it I don't believe that's right". He was "oh you're fucking wrong" and started swearing at me. However I repeat for clarity had we walked through the barrier and paid our train fare the incident with Chris dropping off the wall would not have happened.

I have also been asked about whom else with the family has been asked to take part in this matter. To my knowledge , Daniel has taken the same stand as me in that he disapproves of this claim as well. I believe Daniel may have been asked to provide some references to business and the like.

On the day of this incident I would say Chris had taken his Cannabis. He is a regular smoker of this drug more so than drink. I have witnessed Chris abuse of this over the years.

I would like to add something about the family set up. I refer to Chris as my step dad. That is not strictly the case. I was 1 year old when mum meet Chris I have never really liked him I suppose. He was a violent man towards me. He would on occasions assault me and my family but I am no longer scared of him and do stand my ground with him. This is an emotive subject for me and can make me emotional the way he has treated me and my family. As an example we would get presents for Christmas. Chris would then take the toys and take them to shops and sell them. Although I do not like him that is not my reasons for speaking to the council about

Signed J. S..... .....

CONTINUATION OF STATEMENT OF

this. I do so as I am an honest person and I am not getting involved with this criminal activity. J. S

Signed S.

STATEMENT OF WITNESS

(C J. ACT 1967, s.9, M.C. ACT 1980, Ss5A (3)(a) and 5(B), CPR 2010, r27 2)

STATEMENT OF Daniel

Age of Witness (if over 18, enter "over 18")

Occupation of Witness

The following statement, consisting of page(s) each signed by me, is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated 29.1.2015 Signed [redacted]

My name is Daniel (Son-in-law) My address is known to the authorities and I do not want it disclosed.

I have been asked to produce this statement in relation to a loose relative of mine Chris Furlong also known as "Chrissy" or "Savage" is a step father of sort to my wife Nikki I have known Chris probably for about 18 years. The family consists of Pam (wife), Nikki, mum, Gareth , brother Sam (Not Chris Furlong ') who is Chris's blood son.

I have been asked to clarify some details about my previous companies. I have been involved with the Fire Protection industry for virtually all of my working life. This is what I know and I do best. As a general rule by dad does the business of the accounts, gaining new business and the like. I am more at the sharp end, the actual work end doing the installing and ensuring the site work goes as well as it can do. As a rule I make sure that what the client has asked for we provide in accordance with the drawings and contract detail. Pretty much everything else is down to dad. Currently we are running the main business with a company called Faircroft Fire Limited. Just to explain and make things clear we have previously been trading using similar names. One company in particular, Capital Fire Solutions Ltd, I liquidated the company as I was not paid by companies further up the food chain. Although a regrettable situation for all concerned and especially me this is the very last solution when you are not paid by unscrupulous clients. I am sorry to say that this behaviour is now a frequent occurrence in this industry. It can be very difficult indeed to get the money and sometimes you do not.

[redacted]

I have been asked about Michael This is my father. There is nothing untoward about the difference in the name its just a personal thing.

Specifically in relation to Chris Furlong I can confirm that I have employed him in the past. Nothing permanent just days here and there when the business needed him. Sometimes I paid him in cash but largely paid him through the books.
has had a chequered working history during my time with the family. I am aware that he worked on the railways for a time but that ended with a load of trouble. I can say that we had tendered for and received a contract to do some fire installation work on a building undergoing refurbishment in the city. I believe it was the SECOM Company. We were to start the contract in January 2012 and it may have lasted for up to 2 years. I spoke to Chris before he had his accident about work and agreed I would, whenever I was in a position, offer him some work. I would point out again that this was the basis of an as and when requirement. You can never tell in the construction business what was going to happen next. I was never able to offer Chris a permeant contract it just was not possible in the prevailing business environment. The best I would do was offer him work when I needed him. So in his case It may have been one day this week and then solid work for 3 weeks and some weeks off. Equally there could have been a period when no work materialised. The level and frequency of the work dictate that. There can often be instances when, for reasons beyond my control, work comes to a halt so I simply cannot pay staff to do nothing it has to be productive. This is how this and similar trades work. In relation to the sum of £50,639. I do not recognise this as the sum of money Chris would earn. I do not know where this sum of money came from. The pay structure would be if Chris worked for me for a day I would pay him £100 per day. However that was on a self-employed basis. So he would be responsible for sorting his tax affairs out. In addition if I provided his transport to work then the daily rate is somewhat lower. The more likely rate for Chris was £60 per day as I would anticipate providing transport for him. Also I do not anticipate full time working 50 weeks a year. I do not work that so I wouldn't expect Chris to either. But I make it clear again that the basis of employment was an as and when basis.

Signed .....

The work I had intended to give to Chris was moving bits and pieces here and there, putting things up to ceilings ect. Nearly all of the work is off ladders. If you think about it most of the sensors and wirings are in the ceilings. In office blocks for example, there is invariably a false sealing with a void between then the structural ceilings. The cables and wires for the sensors and alarms are generally fitted to the ceiling itself as the false ceiling probably would not support them. This would require Chris working off a ladders for a considerable amount of the time fixing cables pulling them through voids and walls perhaps. He would need tools and other items to do this up the ladder so you need someone to be rather agile. I would expect that as part of Chris's daily duties he would be moving things like tools, ladders, reels of wires, and other ancillary equipment. This can be heavy and awkward work at times

Also its only correct to point out that at the time in question, January 2012, this was a very busy time for both us and others and work seemed to be readily available but like I have said previously work in this industry is not guaranteed and anything like not getting paid similar to what I have previously mentioned can happen and it can occur with little if any notice.

Regarding Chris's health. Generally he has a few medical issues. I do know of one issue with his heart. He had developed issues with his heart and he was experiencing difficulty breathing. He would keel over and have difficulty breathing. There are a couple of times when he has just keeled over and dropped. I personally have not seen them they have just been brought to my attention from other family members. It is common knowledge in the family.

I know he had an attack just before the incident when he tripped. He was supposed to go into hospital to have a pace maker fitted but he chose not to go and have this done. I have been told his heart is out of rhythm by Chris himself. To the very best of my knowledge he still has not had the mater corrected. I have seen him on his crotches experiencing difficulty generally.

Signed .....

CONTINUATION OF STATEMENT OF

The only thing I know about Chris's accident is that what he's told me is that he fell down a hole when he was with Gareth one evening. He told me that the ambulance crew found him with torches and his leg was smashed to pieces. Taking the injuries to his leg and the heart condition things do not look good for Chris on the medical front.

Signed .....

STATEMENT OF WITNESS

(C.J ACT 1967, s 9; M C ACT 1980, Ss5A (3)(a) and 5(B), CPR 2010, r27 2)

STATEMENT OF Rebecca

Age of Witness (If over 18, enter "over 18") OVER 18

Occupation of Witness

.... HOUSEWIFE..... . ...

The following statement, consisting of 5 page(s) each signed by me, is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

Dated 22 JULY 2015 Signed X .....

This statement I am giving to Beach Borough Council is regarding the family of my ex-partner Gareth . I will refer to him after this as Gary which is what I call him on a regular basis I will also refer to Chris Furlong ' or ' " as he is also known. Although Chris Furlong is generally known as Gareths ; step father this is not the case. I understand that when he was a small baby Chris and Pam mum got together I will also refer to Phil Furlong who I may refer to as Phil. He is, as far as I know the biological son of Chris Furlong Gareth 's mother is ' Pam " her full name is Pamela White She is the ex-partner of Chris .

I want to make it plain, very plain, straight away I disapprove of the way Chris Furlong treats people namely Gary and other family members. This is always a point of contention as I am not afraid to speak my mind with Chris and it is something he does not like. Other people are sometimes scared of him but not me. He is seen as intimidating. However this cuts no ice with me. I do not like him and I do not like the way he treats people. He treats Gary appallingly. Gary has told me of violence Chris has used against him in the past. He swears at him in public and verbally abuses him when there really is no need. He tries to smoke cannabis in front of my young children which I do not allow, he takes what he think he can sell

Signed. X ..... .

CONTINUATION OF STATEMENT OF

for drugs no matter who owns the property and is not afraid to cause trouble when his cannabis is running low. As a parent and as Gary partner I need to set an example of good standards. Also, up to a point, I need to set a good standard to Gary he's my children's father I need to set a set of boundaries for the children and due to Gary having something of a chaotic lifestyle this has proved to be difficult at times and I am sure that this is as a result of the poor influence Chris . has on him. Chris has no concept of an ordered lifestyle especially when children are involved only his own needs.

I meet Gareth on 8th March I think it may have been 2011 12 but I may be mistaken. Our relationship has always been somewhat rocky as he is unable to comply with my house rules for want of a better word. He can be something of a disordered person in chaotic circumstances but there is a lot to like about Gary more than not to like. He is a good father by and large and getting better all of the time. He sometimes comes across as immature and retiring but generally a good person and a good father Me and Gary are currently separated and Gary comes to see the children. This situation could be reversed if Gary grows up and matures.

I have been asked what I know about a claim for compensation by Chris Furlong I first became aware of this when Gary told me Chris had an accident at the rear of a railway station. It was Seapoint I believe. When Gary first told me about it he said he and Chris bunked the train and jumped over a wall. He went onto say that he went to Chris aid and found him on the floor on the other side of the wall. Gary went on that he assisted Chris up to his feet and walked him along the path. An ambulance was called and Chris was in hospital with a broken ankle. Later on Gary told me Gary had put in a claim for compensation against the council and that Chris had asked him to be a witness but when Gary discovered

Signed X.....

CONTINUATION OF STATEMENT OF

what Chris was saying he was very unhappy about it. The story Chris was now telling sometime later was largely different from the earlier version of events Gary told me. The later version of events Gary told me about on the claim, and from what Chris has personally told me over the years, is that Chris was telling everyone that he tripped on a pathway at the rear of the station. On numerous occasions in the years I have known Chris He has told me repeatedly that he fell from the wall onto his ankle and broke it that way. Chris has also told me on many occasions that where the ambulance picked him up from is not where the incident happened. He has always told me Gary moved him and that the drop from the wall was the reason he broke his ankle. He goes on to say that Gary is his only real witness and that he is trying to keep the story as that. When Chris has told me this he has gone on to tell me about the compensation he is going to get which is over £70,000 (Seventy Thousand pounds). Chris has regularly boasted about this in my company and in public. Chris has told me he needs Gary to be a witness on his side as Gary was with him at the time of the incident. I am quite clear that Chris has told me that he received his injuries by jumping over the wall not tripping over a pavement. I have absolutely no doubt about this whatsoever.

In addition to what Chris has told me Gary has also told me what had happened on that night. He has never wavered from his version of events and it has always been consistent. Gary has told me that both him and Chris had been out on the day in question and the early evening they got on a train to go back to Chris property in Beach I think. They got off the train and having no tickets decided to get out of the station avoiding paying the fare. Chris climbed over a wall and dropped down breaking his ankle. Gary went to assist him and moved him along the footpath below the wall. The story Chris was asking Gary to support was rather different. He was

Signed X .....

CONTINUATION OF STATEMENT OF

saying that he tripped on the path. All the time I heard him talk about this over the years he always boasted that the real version was what Gary was saying. At no time did Chris ever provide any reason for being on that path at that time of night. He often joked about it in that he was getting money for jumping over the wall.

There was one incident which I actually witnessed myself. Some post arrived as normal for Gareth opened it and told me it was from some solicitors about the claim. He read the papers and told me that there was a request for him to be a witness to a tripping incident when he was in company with Chris Furlong. was quite firm that he would have no part of it. He ripped the documents up and threw them into the kitchen dustbin. By chance sometime later I meet Chris when I was out shopping in Hull . I was accompanied by my children. I spoke with Chris who was not in a good mood anyway and I told him what Gary had done. He was very angry and started shouting and swearing at me in public. He was shouting in front of my children and ordinary members of the public the words "Fuck" "Cunt". His anger I would say was directed at Gary I mention this for two reasons firstly it is what happened and secondly it was a good example of Chris's poor behaviour and his typical reaction at people when he doesn't get his own way. I would say his refusal to participate in the enterprise with Chris was based on his wanting to do right as opposed to wrong. I suppose it is in a way Gary growing up and accepting responsibility for life and nothing else. Gary has always maintained, and never varied, from his story that Chris Furlong climbed over the wall and hurt his ankle falling from the wall. Gary picked him up and walked him along the path where an ambulance was called. I have always been somewhat annoyed with Chris and this claim. I have witnessed him with 2 crutches outside in public. When he is inside things are different. He discards them and goes about his business inside as

Signed X .....

CONTINUATION OF STATEMENT OF

normal without the need for the crutches. He for example goes up the stairs which I have seen him do and he will do other normal things without issue. He is somewhat apprehensive of being photographed by people without them so when he leaves he always checks that the crutches are on display.

I also have been made aware that 'Gareths mum as I previously mentioned, had a conversation with Gary's sister. This may have been on Sunday just gone. Pam told Gary's sister that she was aware that Chris Furlong had forged Gary's signature on a statement from Chris's solicitor and returned it to them. I would be surprised, very surprised, if Gary signed this statement as he has always been consistent that the only statement he would sign would be one containing the leaping over the wall and not the tripping as the tripping never happened. Gary's version of events has always been confirmed in unguarded conversation with Chris.

Signed X.....